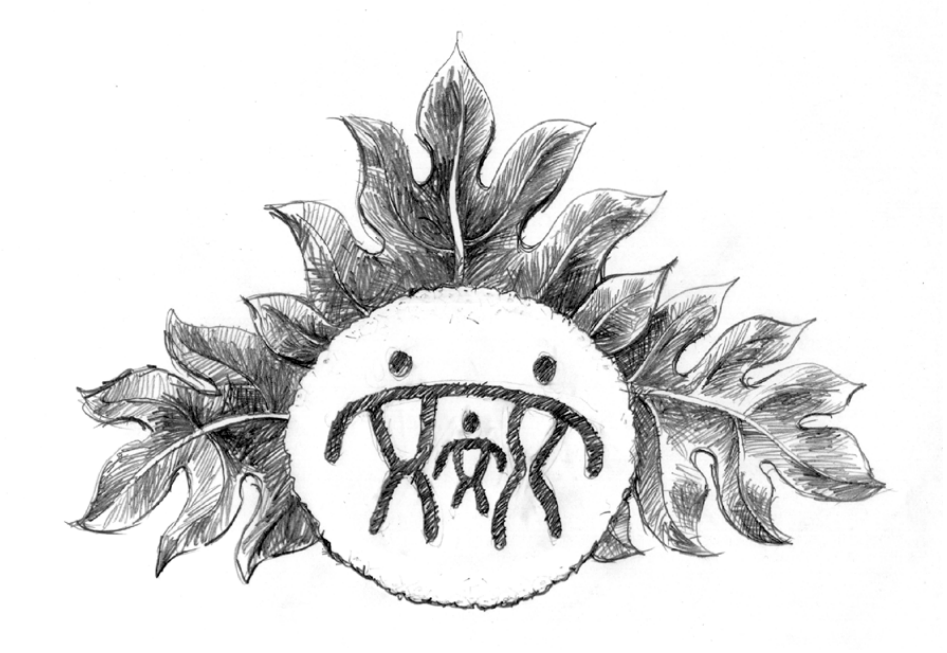
Native Hawai‘ian Youth Suicide Prevention Project

No Ke Ola Pono o Ke Kaiaulu

"Establishing a Community Lifestyle in Balance"

A Manual for Gatekeeper Trainers



Hawai‘i Department of Health

Injury Prevention and Control

Emergency Medical Services System

Maternal and Child Health

September 1999

Native Hawai‘ian Youth Suicide Prevention Project

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A Manual for Gatekeeper Trainers

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This manual has been adapted from the *"Preventing Youth Suicide through Gatekeepers Training: A Training Manual for Gatekeepers,"* written and edited by, Loren Coleman and Susan O'Halloran, 1998, for the Maine Department of Human Resources, Bureau of Health. Other credit and citation information may be found in the specific sections and at the back of this manual.

September 1999

Foreword

This Native Hawai‘ian Gatekeeper Training Manual was designed to be used as an integral part of an interactive training with qualified Gatekeeper Instructors. Its sole purpose is to serve as a resource for individuals who complete the gatekeeper trainer of trainers program. The manual is in no way a comprehensive look at suicide, nor is it a treatment manual. It is not intended to be a stand-alone suicide prevention effort.

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Cover graphic based on a concept by Hale Ola Ho‘opakolea Incorporate. Imagery is a necessity when communicating in the Hawai‘ian language and culture. Hawai‘ian thoughts are very difficult to capture literally by the English language. The following are examples to help translate these images of Ulu, the breadfruit when used in this context. Growth, increase or rising in the wind, to protect i.e. ulu ehuehu: to grow fast as a child. Ka ulu o ka la – the rising of the sun. Ho‘oulu lahui – to increase and preserve the nation. Said to be the aim of King Kalakaua. Kaiulu – sea at full tide. Ulukou, ulukukui, ulula‘au, ulunui – groves, clusters of trees. Uluhoku – cluster of stars.* ‘Ohana petrograph: represents community in the broader sense of family.

** Source: Pukui, Mary Kawena and Elbert, Samuel H., Hawai‘ian Dictionary, University of Hawai‘i Press, Honolulu.*

Contents

PAGE

Rationale for Gatekeeper Training

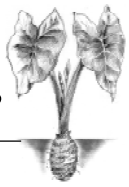
Unless involved in the mental health field, few people have in-depth knowledge about suicide. Nevertheless, suicide touches the lives of most people. It is an emotionally charged topic with a long history clouded by myths and misconceptions. Misinformation perpetuates the personal and social elements related to suicide including denial, shame, stigma, fear, and guilt.

Recent years have brought a marked increase in research, knowledge, clinical services, and public awareness about the topic of suicide. Research is showing that a combination of particular prevention efforts promises much hope. One promising suicide prevention strategy, highly recommended by the Centers for Disease Control is Gatekeeper training. Gatekeeper training is a community based prevention program, designed to train nonprofessional people in the community in basic suicide prevention skills.

This gatekeeper training is part of a program designed to provide participants with:

- General knowledge about the nature of suicidal behavior
- Specific skills to recognize suicide risk, respond appropriately, and refer a suicidal person for help
- Strategies to support youths known to be at high risk for self-destructive behaviors
- Knowledge about the referral and crisis response system

The participants will be asked to create and present basic Gatekeeper training to interested parties including: school faculty, administration and staff, students, and community groups.



Youth suicide is a growing problem nationwide. Suicide mortality rates in the United States have tripled since 1950 and continue to rise. Each year approximately 5000 youth under the age of 25 die by suicide, in the United States - and each death is a tragedy.

In Hawai‘i suicide has become increasingly recognized as a problem among our youth. Recent Youth Risk Behavior Survey data demonstrate rates of suicidal behavior (suicidal ideation, suicide plans, suicide attempts) significantly higher than the national average.

- In Hawai‘i suicide is the second leading cause of death for persons 15 - 24 years old.
- Nearly 30% of teens report that they have seriously considered suicide, 27% of them having contemplated suicide in the past year.
- 20% of Hawai‘i’s teens have made a suicide plan in the past year.
- 12% of teens have made a suicide attempt.
- Approximately 20 youth (ages 15-24) committed suicide each year in the state.
- While completed suicide in younger teens (12-14 year old) is relatively rare, we lose 3 - 4 youth in this age group each year.

Among Native Hawai‘ian youth, suicide rates are greater than that found for other populations in the state. The disproportionate number of suicides in Native Hawai‘ians are found primarily in children and young adults, while older Native Hawai‘ians have comparable or even lower suicide rates than the state average.

- Approximately 6-7 Native Hawai‘ian youth (ages 15-24) commit suicide each year.
- While Native Hawai‘ians account for only 27% of the 10 - 14 year old population in the state, they account for 50% of the suicides in this age group.
- In the 15 - 19 age group, Native Hawai‘ians comprise approximately 25% of the population in the state, but account for 40% of the suicides in this age group.
- Rates of attempted suicide are significantly higher for Native Hawai‘ian youth (12.7% vs. 11.4%).*
- In particular areas, suicide attempt rates for Native Hawai‘ians are extremely high (approximately 18% of Native Hawai‘ian adolescents report that they have attempted suicide).

** Source: Yuen, N.; Nahulu, L.; Hishimura, E.; and Miyamoto, R. “Native Hawai‘ian Medical Health Research Project.”*

SECTION I.

- Terminology
- Myths of Suicide

The language of suicide is expressed differently by various generations, genders, and ethnicities. In this manual, suicide-related behaviors include any potentially self-injurious behavior for which there is evidence the person intended at some level to kill him- or herself or wished to convey the appearance of intending suicide for some other reason, such as punishing others or receiving attention. It is important to understand that the behaviors appear on a continuum. The behaviors are listed below to reflect increased intensity of suicidal behavior as it moves from risky behavior to a completed suicide.

Risk-taking Thoughts and Behaviors
While not necessarily suicide-related, these are ideas and actions for which there is a high likelihood of injury or death, including engaging in reckless sports, undertaking dangerous activities, and driving after consuming a large amount of alcohol.

Suicidal Ideation
Any self-reported thoughts or fantasies about engaging in suicide-related behavior. Example: A young person's English class journal entry describes intense feelings of sadness and thoughts of suicide, death, or "ending it all."

Suicidal Threat
Any interpersonal action, verbal or nonverbal, indicating a self-destructive desire, but stopping short of a directly self-harmful act, that a reasonable person would interpret as a suicide-related communication or behavior. Example: A young mail threatens to kill himself if his girlfriend breaks up with him.

Suicidal Act or Suicidal Gesture
A potentially self-injurious behavior or act symbolic of suicide, but not a serious threat to life. The act may accidentally result in death, injuries, or no injuries.

Suicide Attempt
A nonfatal outcome for which there is evidence (either explicit or implicit) that the person believed at some level that the act would cause death. A suicide attempt may or may not cause injuries. Attempted suicides include acts by persons whose determination to die is thwarted because they are discovered and resuscitated effectively. The individual frequently, reports that the intention was to die. There is a fine line between a suicide gesture and a suicide attempt.

Sub-intentional Death
Covert or subconscious act of placing self in very vulnerable position, such as victim precipitated homicide, wandering out into oncoming traffic, or jumping out of a moving vehicle.

Suicide or Completed Suicide (terms can be used interchangeably)
Someone takes his or her own life with conscious intent by lethal means, for example, injury, poisoning or suffocation. The use of the word “successful” to describe suicide is discouraged.

Suicide Pact
Joint Suicides of two or more individuals (close friends, lovers, etc.) which are the result of an agreed upon plan to complete a self-destructive act together, or separately but closely timed. Suicide pacts are a very real part of suicidology and historically have been represented in fiction as well as fact.

Contagion or “Copy-Cat” Suicide
A process by which exposure to suicide or suicidal behavior of one or more persons influences others to attempt or commit suicide. Nonfictional media coverage of suicide has been associated with a statistically significant excess of suicide, which appears to be strongest among adolescents. Several well-publicized, “suicide clusters” have occurred. Citizen/community education is vitally important to reduce this risk.

Murder-Suicide
Not to be confused with a suicide pact, this is an event in which one individual murders one or more people and then takes their own life by suicide. The murder victims may be family members, friends, acquaintances, or strangers.

There are a number of commonly held incorrect beliefs about suicide. These myths stand in the way of providing assistance for those who are in danger. By removing the myths, those responsible for the care and education of young people will be more able to recognize those who are at risk and provide the help that is needed.

Myth #1: Young people who talk about suicide never attempt or complete suicide.
Fact: Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Those who are most at risk will also show other signs apart from talking about suicide.

Myth #2: Suicide is hereditary.
Fact: Although suicide can be overrepresented in families. There is no "suicide" gene. Members of families share the same emotional environment and the completed suicide of one family member may well raise the awareness of suicide as an option for other family members. Suicide is seen as one model for "coping" in some families and, therefore, it's continued expression in certain families should be taken very seriously as a "risk factor."

Myth #3: Once a person is intent on suicide, there is no way of stopping them.
Fact: Suicides can be prevented. People can be helped. Suicidal crises can be relatively short-lived. There are immediate practical ways in which anyone can help a suicidal person. They include: staying calm and listening, ask directly about suicidal thoughts, take all threats seriously, get help. Don't try to take on the total responsibility of this person's life. Refer to appropriate treatment.

Myth #4: All suicidal young people are depressed.
Fact: While depression is a contributory factor in most suicides. It need not be present for suicide to be attempted or completed. In fact, some people who are suicidal appear to be happier than they've been in years because they have found a "solution" to all of their problems.

Myth #5: There is no correlation between alcoholism and suicide.
Fact: Alcohol/drugs and suicide often go hand in hand. Alcohol and other substances of abuse increase impulsivity and cloud judgment. Even people who don't normally drink will often do so shortly before killing themselves, to gain the courage to commit suicide. Alcohol is a factor in at least a fourth of youth suicides.

Myth #6: Suicidal young people are insane or mentally ill.
Fact: Although suicidal adolescents are likely to be extremely unhappy and may be classified

as having a mood disorder, such as depression, most are not legally insane. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.

Myth #7: Once a young person is suicidal, they will be suicidal forever.

Fact: Most young people who are considering suicide will only be that way for a limited period of their lives. Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns. If counselors and other mental health professionals can monitor the adolescent during a crisis period and help place him or her into long-term counseling therapy, there is a strong possibility that the adolescent will not have another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during this post-suicidal crisis period, and the more time that passes, the better the prognosis.

Myth #8:Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

Fact: Most people thinking about suicide want very much to talk about how they are feeling and are relieved when someone else recognizes their pain. To avoid the subject of suicide can be deadly. Once you ask someone about suicide and they respond "yes," you must be prepared to stay calm, take the time to listen, and to persuade them to get help. If a suicidal person thinks you know he or she is suicidal and realizes you are afraid to approach the subject, it can contribute to the person's feelings of despair and helplessness.

Myth #9: Suicide is much more common in young people from higher or lower socioeconomic groups.

Fact: The causes of suicidal behavior cut across SES (socioeconomic status) boundaries. While the literature in the area is incomplete, there is no definitive link between SES and suicide. This does not preclude localized tendencies nor trends in a population during a certain period of time.

Myth #10: A promise to keep a note unopened and unread should always be kept.

Fact: Where the potential for harm, or actual harm, is disclosed then confidentiality cannot be maintained. A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note can be a late sign in the progression towards suicide.

Myth #11: Attempted or completed suicides happen without warning.

Fact: The survivors (friends and family of the deceased) often say that the intention was hidden from them. It is more likely that the intention was not recognized. Research has demonstrated that in over 80% of completed suicides, a warning sign or signs were given.

Myth #12: People who threaten or attempt suicide are merely seeking, attention.
Fact: All suicide threats and attempts must be treated as though the person has the intent to die. Do not dismiss a suicide threat or attempt as simply being an attention-gaining device. It is likely that the young person has tried to gain attention and, therefore, this attention is needed. The attention that they get may save their lives.

Myth #13: Suicide is painless.
Fact: Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain. The pain to the suicide victim, of course, extends to the survivors of the victim too over longer period of time.

Myth #14: Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.
Fact: The opposite may be true. In the three months following an attempt, a young person is at most risk of completing suicide. The apparent lifting of the problems could mean the person has made a firm decision to commit suicide and feels better because of this.

Myth # 15: Suicidal young people cannot help themselves.
Fact: Whilst contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain the life skills necessary to manage their lives.

Myth #16: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.
Fact: All people who interact with suicidal adolescents can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

Myth #17: Most suicidal young people never seek or ask for help with their problems.
Fact: Evidence shows that they often tell their school peers of their thoughts and plans. Adolescents are more likely to ‘ask’ for help through nonverbal gestures than to express their situation verbally to others.

Myth #18: Suicidal young people are always angry when someone intervenes and then, will resent that person afterwards.
Fact: While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone, genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.

Myth #19: Every death is preventable.

Fact: While this is true theoretically, no matter how well intentioned, alert, and diligent people's efforts may be, it is impossible to prevent all suicides. Human nature is difficult to predict. It is important to realize that we will not be able to save everyone.

Myth #20: If a person attempts suicide and survives, he or she will never make another attempt.

Fact: Although an individual who has made a suicide attempt will often feel remorse for having attempted suicide, they are at greater risk for another suicide attempt than the person who never attempted suicide. If many of the precipitating stressors have not been resolved, additional attempts may be made.

SECTION II.

- Risk and Protective Factors for Suicide
- Suicide Warning Signs and Clues
- Asking About Suicide
- The Suicide Contract

What to Look For

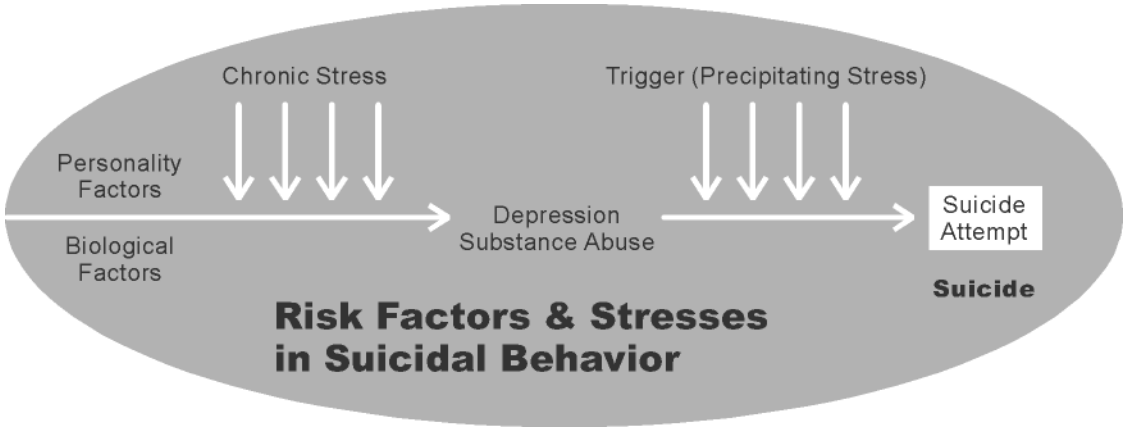
Most people who contemplate suicide do not want to die.
They simply feel there is no other way to escape the pain which has become unbearable. Until the time they attempt suicide, they are ambivalent about dying and want to believe that there is help, a way out of their problems. Many people are depressed and feel isolated, often feeling that no one cares about them and that they are not worthwhile enough to trouble someone with their problems. Very often they will have been contemplating suicide for some time before committing suicide and will show signs of depression, despair and hopelessness.

To recognize a suicide crisis you must have knowledge of the potential risk factors, the warning signs, and other clues.
Given that adolescence is a time of great change and mood swings, viewing a young person who may be at risk for suicide from many perspectives is important. Avoid giving any one sign too much significance. Look for the number of signs, the pattern (several related signs), the duration (two weeks or more of a given pattern), and the intensity of a particular crisis event. Pay special attention to any signal that suggests despair, isolation, depression, distress, and hopelessness. Take the perspective of the person who may be suicidal, and pay attention to your “gut “feelings. It is the combination of feelings and events that may be lethal. Remember, if you are concerned about someone you think might be suicidal, chances are if the thought has crossed your mind, it has already crossed their mind.

Suicide Prediction

There is no single risk factor which by itself predicts suicide. It is usually a combination of ongoing stresses, depression and a series of precipitating events that convinces a person that their situation is hopelessness and leads that person to contemplate suicide.

Although there is no model to date which fully accounts for the reasons that a person commits suicide and there is no foolproof way to predict suicide, even when faced with the risk factors, the following model has been helpful in understanding how risk factors and stresses interact to lead a person to suicide.



Although some suicides are impulsive, committed at the spur of the moment, most individuals have been shown to be depressed and suffering from a variety of stresses over a period of time.

Not uncommonly a single stress (such as fight with a boyfriend etc.) will be the straw that breaks the camel's back, and may appear to be the single event which lead to suicide. However, in actuality it is usually the last stressor (the precipitating stressor) in a series of stresses which lead the individual to feel that they could no longer cope with the pain.

Risk Factors for Suicide

Previous suicide attempt

Approximately 50% of people who make a serious suicide attempt have attempted suicide before. 41% of them were made within a year prior to the attempt.

Gender

- Males commit suicide 4-5 times more frequently than females and account for 80-90% of all suicides.
- Females attempt suicide 3-5 time more frequently than male, but males use more lethal methods and thus succeed more often when they do make an attempt.

Depression

Nearly every person who commits suicide has been depressed to some degree or another. Depression may not always be evident. Some people are very good at hiding their depression. (See warning signs for a description of depressive symptoms.)

Other psychiatric disorders associated with depression and suicide

- Bipolar disorder (manic-depressive illness)
- Eating disorders
- Anxiety disorders - Panic disorder, Obsessive-compulsive disorder
- Schizophrenia
- Personality disorders particularly Borderline Personality disorder
- Conduct disorder/ Antisocial Personality disorder

Drug or alcohol abuse

Youth who drink alcohol are more likely to act on suicidal thoughts and plans. Alcohol worsens depression and in some cases may cause depression. It also causes people to become more impulsive, more likely to act on suicidal thoughts. Some people who are too afraid to commit suicide while sober, will become purposefully intoxicated in order to “have the courage” to carry out a suicide plan. Conversely, some individuals who are suicidal while drunk will no longer feel suicidal once sober.

Perfectionistic personality traits

Certain personality traits have been found amongst people who commit suicide. Individuals with unusually rigidly perfectionistic personalities tend to be at higher risk for suicide. It is likely that such individuals become depressed when they cannot live up to their expectations for themselves.

Impulsive and aggressive personality traits

Individuals with poor impulse control are much more likely to act on a suicidal impulse before

having thought through the situation or attempted to work through their problems. There are also more likely to engage in risky, dangerous behavior when upset and emotionally distraught.

Poor coping skills
Very often people who contemplate suicide feel overwhelmed by stress to the extent that they can no longer cope and see no way out of their problems.

Poor problem solving skills
People who are suicidal often feel overwhelmed by problems in their life and feel that there is no way out of their problems. They may have difficulty problem solving ways out of their difficulties and become more susceptible to feelings of hopelessness and despair. Depression may impair a person's ability to see situations objectively and may impair problem solving abilities.

History of physical or sexual abuse
Whether the abuse is chronic or acute, physical and sexual abuse creates tremendous stress often overwhelming an individual's ability to cope. A disproportionate number of teens who commit suicide have a history of abuse.

Gender identity issues
Gay youth are 2-3 times more likely to attempt suicide. These youth face intense emotional conflicts over their emerging sexuality, concerns about societal and family disapproval, and fears of alienation associated with "coming out."

Poor family support
Adolescents who attempt suicide are much more likely to have experienced family turmoil (parental separation or divorce, change in caretakers or living situation, decreased social stability). Those who attempt suicide report lower perceived support from their family.

Suicide of a friend or family member
Adolescents who attempt suicide are 7 times more likely than non-suicide attempters to have a family member who has attempted or completed suicide.

In the aftermath of the death of a close friend or family member, many people will become depressed. Sometimes those close to the individual who committed suicide are so caught up in the grief and trauma of the situation, that there is no support for a grieving individual. The individual may feel a terrible sense of loss and isolation and become suicidal themselves.

Suicide also tends to be more common in family members of a person who committed suicide. It may be that depression or substance abuse runs in their family. It may be that suicide was modeled as an option, when one's situation in life become difficult.

Protective Factors

Protective Factors are the positive conditions, personal and social resources that promote resiliency and reduce the risk of suicide.

- Supportive relationships, particularly a supportive family
- Religious/spiritual beliefs - particularly those that prohibit suicide and stress the value of life
- Life skills (decision making, problem solving, anger management, conflict management)
- Good impulse control
- Flexibility in approach to problems
- Responsibilities and duties to others
- A healthy fear of risky behavior and pain
- Difficult access to lethal mean to harm self
- A sense of personal control over one's life

For a comprehensive list of developmental assets, see Appendix C.

Precipitating Stresses

Any stressful event or situation is potentially capable of precipitating suicide or a suicide attempt in a susceptible individual. What is stressful for one person may not be stressful for another and visa versa. Keep in mind that while none of these single stresses by themselves is likely to cause someone to commit suicide, there are usually a series of stress (chronic and/or acute) in combination with depression, which lead to suicide.

Stresses common to individuals who attempt/commit suicide:
(may be chronic or acute)

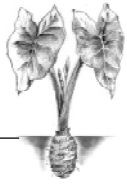
- Poor family support and/or family dysfunction
- Conflict with parents or siblings
- Foster placement
- Physical abuse
- Sexual abuse
- Confusion about sexual orientation
- Conflict with boyfriend/girlfriend
- Conflict or isolation from peers
- Academic difficulty
- Legal difficulty - arrests, probation ,etc.
- Divorce in family member

Examples of precipitating stresses:

- Break up of a relationship (e.g. with a girlfriend/boyfriend) or separation
- Fight or argument with girlfriend/boyfriend
- Fight or argument with parents or family member
- Academic failure
- Disciplinary action in school or at home (e.g. suspension)
- Unwanted pregnancy
- Loss of a close family member or friend through death, divorce, moving away

Completed suicide is most often immediately precipitated by:

- A shameful or humiliating experience, e.g. failure at school
- A disciplinary action, e.g. suspension from school, arrest
- Intense interpersonal conflict with a girlfriend/boyfriend or parent



Warning signs are external signs, detectable by others, that signal suicide risk.

Indirect Warning Signs

Symptoms of Depression:

- change in personality
- depressed mood - Appearing sad or moody nearly all the time.
- irritability - Depressed adolescents may appear more sullen and angry, more ready to snap at people with minimal provocation, demonstrate a lower frustration tolerance and less patience than usual.
- change in sleep patterns
- insomnia
- difficulty falling asleep (often staying up for hours preoccupied with all the things going wrong in their life).
- waking up frequently at night, may or may not be able to fall back to sleep right away.
- early morning awakening - Waking up before the usual wake up time, unable to fall back to sleep, despite feeling tired.
- hypersomnia - Sleeping more than usual, for example sleeping 10 hours at night, and sleeping throughout the day
- lack of energy - People describe feeling unable to get out of bed in the morning, struggling to make it through the day, fatigued and exhausted. In adolescents this may manifest as falling asleep in class, tardiness in the morning (oversleeping in the morning) etc.
- psychomotor retardation - Slowness of movement and speech.
- change in appetite
- decrease in appetite, often with weight loss
- or increase in appetite, often with weight gain
- decrease in self-esteem - Even individuals who ordinarily have a healthy self-esteem, may experience a drastic decrease in self esteem when depressed. Statements indicating low self esteem include:
  - “I’m such a failure”
  - “Nothing I do is any good”
  - “Nobody likes me”
- feelings of hopelessness - Verbalizing statements such as:
  - “Nothing works anymore”
  - “It’s useless”
  - “Nothing can help”
- anhedonia (inability to enjoy things)
  - “Nothing seems fun anymore”

- social withdrawal - Withdrawing from friends and family, choosing to be alone rather than with friends, avoidance of social interactions and conversation, e.g. staying in the bedroom all day, sometimes lying in bed all day declining opportunities to go out with friends.
- decreased cognitive ability - May be associated with decline in academic performance, decreased concentration, slowed thinking, memory impairment, forgetfulness or absent mindedness.
- inability to see events and circumstances in a positive light - Seeing everything from a negative point of view, imagining the worst in a situation.

Direct Warning Signs

- preoccupation with themes of death in written material or drawings, e.g. journals, poems, artwork, or in speaking. For example:
  - "What would you do if I wasn't around?"
  - "Would you miss me if I were dead?"
- stating outright a desire to die
  - "Life is just too hard, I feel like dying"
  - "I want to kill myself"
- engaging in high risk behaviors, e.g. reckless driving at high speed, jumping off of high areas, driving the wrong way down a one way street
- giving away possessions
- purposefully putting personal affairs in order, e.g. clearing the air over personal incidents from the past
- saying good-bye to loved ones
- writing a suicide note
- verbally saying goodbye to family and friends
- sudden lifting of mood after a period of severe depression - This may indicate that the individual, after having struggled with the desire to kill themselves, has come to a decision to commit suicide and is experiencing a sense of relief at having made the decision.
- gathering materials to be used to commit suicide
- hoarding medication
- keeping knives in the bedroom, under the bed
- hiding a gun in the bedroom
- playing with knives or ropes

Setting

If possible try to find a private place to talk. In the school setting, possible places to talk might include the teacher's workroom, teacher's lounge, unused space in the administration building, or outdoors where you might find a place away from other students.

Getting Someone to Talk About Personal Matters

- Be open to what students have to say.
- Listen to them without judging them or making them feel stupid or "mental" for saying it.
- Be empathic.
- Start with open ended questions (questions that can't be answered with a "yes" or "no"). For example:

  "How are things going?"

  "What has been going on?"

  "What seems to be upsetting you?"

  It is often useful to combine an empathic statement, followed by an open ended question. For example:

  "You seem upset. What's bothering you?"

Suicide Related Questions

Less direct approach

First inquire about the person's emotional state: (Ask a general question)

"How are you feeling?"

"Have you been feeling sad or upset lately?"

Then narrow down the questions:

"Do you ever feel so bad that you don't think you can stand it anymore?"

"Does the pain ever get so bad that you think about what it would be like to be dead?"

More direct questions

"Have you thought about hurting yourself?"

"Are you thinking about hurting yourself now?"

"Have you thought about killing yourself?"

"Are you thinking about suicide?"

It is important to feel comfortable in asking about suicide. Don't ask the questions in a joking manner. For example, do not say:

"You're not suicidal are you?"

"What? You're suicidal?"

This puts people on the defensive and even someone who is considering suicide may deny it, when asked in this way. We sometimes ask about suicide in a joking way, to hide our own discomfort about the subject. **Be serious and direct.** Practice asking the suicide questions until you can do so comfortably.

Inquire about a plan

Have they chosen a method?

"Have you thought about how you would do it?"

(If yes, assess how specific and realistic a plan they have devised)

The more lethal the method, the greater the suicide risk.

How detailed is the plan?

(The more detailed and well thought out the plan, the more likely they will commit suicide.)

How accessible is the method they have chosen?

(e.g. If they plan to shoot themselves, is there a gun in the home? Do they have bullets?)

Have they chosen a time frame or a date when they will do it?

"Have you decided when you would do this?"

Have they taken steps to carry out the plan?

"Do you have a rope (gun, knife etc.)?"

"How would you get it?"

"How difficult would it be for you to get a rope (gun, knife etc.)?"

Inquire about intent to kill themselves

If they answer positively to suicidal ideation and a plan, you want to determine how intent they are on killing themselves. People remain ambivalent about suicide until the very end, but some people are more determined and decided to kill themselves than others. Most people are afraid of their suicidal thoughts and impulses and will do everything in their power to fight off such thoughts and urges. It is important to assess how much they really want to kill themselves.

"Do you feel that you will actually kill yourself?"

"Do you feel in control, where you'll stop yourself from hurting yourself?"

"If I had a gun here and you were alone, what would you do?

Assessing impulse control

Most people do not want to commit suicide, but have suicidal thoughts and urges which they frequently battle internally. They feel there is no other option and feel they the pain is so intolerable that suicide becomes the only way to escape. It is important to determine how well a person is able to control the suicidal impulses.

How in control of their emotions and actions do they appear?

- Is the person agitated?
- Is the person intoxicated with alcohol or drugs? (which impair impulse control and ability to think clearly)
- Does this person look in control of themselves, not to act on their suicidal impulses, when they say they won't?

Ask them whether they are in control

"Do you feel in control of your suicidal urges?"
"Do you feel that you **will** harm yourself?"
"Are the suicidal thoughts so bad that you can't trust yourself to be safe?
To stay alive?"

TRUST YOUR GUT REACTION

If you feel uncomfortable about their safety, even if they answer negatively to the suicide questions, refer them for help.

What is a Suicide Contract?

The suicide contact is an agreement (verbal or written) between yourself and a student whom you feel to be at risk for suicide, but who is not acutely suicidal. The suicide contract is meant for low risk situations. It is not expected to hold for a person at high risk for suicide i.e. do not use it for someone who is acutely suicidal, expecting them to keep themselves from committing suicide because of a promise to you.

Ask the student to contract with you to notify you if they feel suicidal so that you can talk things over before they act on a suicidal urge.

Examples of Low Risk Situations

(Appropriate for a suicide contract)

- A student may have occasional thoughts of suicide, but none currently.
- A student may have many of the risk factors and feel under stress, but denies feeling suicidal.
- A student may have made a suicide attempt and upon returning to school feels better (non suicidal), but is still somewhat depressed.

Examples of High Risk Situations

(Too risky to trust a suicide contract)

- A student has been thinking of suicide daily, has thought of ways to do it
- A student has suicidal urges, appears agitated even though they have no plan and deny intention to harm themselves.
- A student has suicidal thoughts and doesn't feel able to control the urge to kill himself

NOTE: Just because a student forms a contract with you doesn't mean that it will keep them from committing or attempting suicide. It does however allow you to:

- get a sense of their impulse control and the seriousness of their suicidal ideation,
- demonstrate to them how much you care about them and are willing to listen to their problems
- it gives the student some guidance in terms of what to do when they do feel suicidal (i.e. who to turn to).

However, when someone is seriously suicidal, they may make a suicide attempt whether or not they have formed a contract with you.

IT CAN'T BE EMPHASIZED ENOUGH: Trust your gut reaction whether or not a person forms a suicide contract with you.

SECTION III.

- What to Do If a Student is Suicidal
- After a Suicide Attempt
- Guidelines for Schools Managing a Suicide or Sudden Death
- Suicide Cluster
- Teen Suicide Cluster Checklist
- Featuring Suicide in the Media: Avoiding Contagion - Promoting Help
- Crisis Response Protocol & Referral Procedures

What to Do?

- Don't leave the student alone and unattended.
- Stay calm, try not to panic - panicking only makes the student feel that you aren't in control either and will increase their sense of chaos.
- Don't expect to be able to talk them out of suicide - even if they say they change their mind, you can't trust that they will not make a suicide attempt once they are away from you and the pain and stress returns.)
- Inform the student that for their safety you must get help.

What Do You Say?

- Let them know you understand their pain.
  "It must be miserable to feel this way "
  "I can only imagine the pain you're in"
  "It must have been difficult to have dealt with this all on your own"
- Express your concern for their safety
  "I'm really worried about you."
  "I'm worried that you are really going to hurt yourself."
- Then tell them that for their sake you are going to get help
  "I'm really worried that you'll kill yourself. I'm going to get someone who can help."
- Let them know that the pain is only temporary (that there is hope)
  "As bad as it feels right now - it won't be like this forever."
  "It only feels like things won't get better."
  "I know it must be hard to think of anything getting better, but it will."

While You Are Waiting for Help

- Continue to listen to their problems.
- Continue to validate their feelings.
- Don't try to minimize their problems. For example, don't say:
  "That doesn't sound so bad"
  "I know people who went through a break up and they did OK."
  It only makes the person feel worse, that their problems aren't so bad and some thing is wrong with them because they can't handle it. It also increases their sense of isolation, feeling that no one is able to understand their pain.

- Don’t make them feel bad about feeling suicidal - they can’t help how they feel. Don’t say:

  “How come you’re feeling suicidal?”

  “Haven’t you tried dealing with it?”

  These statements make a person feel judged for feeling suicidal. It only reinforces to them that they aren’t supposed to be feeling suicidal, and they must be a bad person for feeling this way.
- Don’t validate suicide as an option. At times people can be so empathic and understanding of a person’s pain that they overvalidate their feelings, even feelings of suicide.

  “I can see why you’ve considered suicide. Life just seems too hard”
- Rather, validate the person’s feelings, but let them know that there are better options than suicide.

  “I can see why you’ve considered suicide. Life just seems too hard, but there’s always a better way out than suicide. Let me try to help you figure out some options.”

Returning to school to face teachers and peers is often one of the most difficult things a student will have to do following a suicide attempt - particularly if the suicide attempt becomes well known across campus. Students often feel a sense of shame and may worry that other students will view them as "mental." These feelings and concerns are intensified if they required psychiatric hospitalization for their suicide attempt. Also, keep in mind that students may still feel quite depressed and may continue to experience some low level suicidal ideation for quite a while after a suicide attempt and/or hospitalization.

A supportive, non-judgemental approach is helpful in easing their adjustment back to school. If you have a personal relationship with the student, and particularly if you are the person who screened them for suicidality - you will already have built up some trust with the student. It is important to let them know that you care - that you are concerned for their welfare. It is bound to feel awkward for the student, but the more at ease you are in talking with them and listening to them, the more comfortable they will feel. This is your chance to further your relationship with the student.

Below are some suggested ways to approach a student who has just returned from a suicide attempt.

Start out with a general open ended question, such as:

"How are you doing?"
"How's everything going?"

Let them know you are happy that they didn't kill himself.

"I'm relieved that you didn't harm yourself."

Be ready to recheck for depression and suicidal ideation.

"Do you still feel depressed at times?"
"Do you feel depressed even now?"
"Do you still think about hurting yourself?"

Let them know that you don't want them to attempt suicide again.
And be ready to set up a suicide contract

"I'm glad to hear that things are better."
"I really don't want you to hurt yourself again. If you ever feel bad enough that you want to kill yourself, will you promise that you will talk to me and tell me about it. We'll work out the problems together."

Let them know you are there to listen to any problems they have

"Anytime you like, come by and talk."

Continue to build a relationship of trust and friendship.
For example invite them to come by - if only just to hang out. You don't always have to talk about personal problems.

If the student wants to share their experience in the hospital, encourage them to do so. If they don't feel like talking about it - respect their need for privacy.

NOTE: Most adolescents who have received medical attention, particularly if they were hospitalized, will follow up with some sort of counseling or therapy. However, a fair number of adolescents, and their families, do not follow up with any sort of counseling, or if they do it may be very short term. The school, a special teacher, a PEP student, may be the only person staying in contact with the youth. **YOU** may be the person the student chooses to talk to. You are not expected to be a therapist or a counselor. You are not a mental health expert. But you can be a friend and listen to their problems and you can monitor them for any recurrence of suicidal ideation. **This is the role of the gatekeeper.**

Day of Suicide / Death

1. School principal initiates “chain call” to all faculty and support staff informing them of the suicide and requesting their arrival at school 30 minutes earlier to attend a special faculty meeting.

2. Telephone conferences with crisis team members are held to plan tentative activities for the next day (day after a suicide).

First Day After a Suicide / Death

1. School principal meets with crisis team 30 minutes before meeting with faculty to plan the aftermath of the suicide.

2. Principal reviews the facts of the case with all the faculty and support to dispel rumors, to discuss the plan of the day, and to allow for faculty members to express their feelings. Faculty/ staff are encouraged to lend support to one another.

3. A member of the school crisis team or a mental health center worker gives the faculty all the facts of the death. A member of the crisis team describes some of the feelings the students may be experiencing following the death of a classmate ... disbelief, anger, denial, sadness, loss. Suggestions are reviewed on ways to encourage the expression of grief in their classes.

4. A crisis center is established in the guidance office or similar safe “space.” Additional personnel/staff from other buildings and from neighboring school districts may be called in to assist with the crisis. Staff from your local mental health center can be helpful. A member of the crisis team makes phone calls to parents of students who are particularly upset or may be at risk. The crisis team member can explain the students’ reactions to the death and can make appropriate suggestions to parents on ways to manage/support their children through the crisis. It may be necessary for parents to come to school and take the youth home for the day or to receive immediate professional help. Resources for professional help are made available.

5. A call is made by the principal or designee to the local mental health center (if not done sooner) to notify them of the problem of the youth suicide or sudden adolescent death and arrangements are made to elicit help from them.

When *outside* consultants are called upon, they can be useful because they are generally not emotionally involved with the case and can provide objective support and direction. Some of the services they provide are:

- Individual counseling for students.
- Speaking at a general faculty meeting on the issue of adolescent suicide: identification, prevention, response, and help with some other concerns generated in staff or in students.
- Conducting evening informational meetings for all concerned community members.

6. "Peer Facilitators" (if your school has a peer support program) are assembled to work through their feelings, and the crisis team members can offer them some guidelines for helping their troubled friends.

7. School staff is assembled for one hour (minimum) at the end of the school day. The principal conducts the meeting and does the following:

- Allows for the expression of **feelings,** and mutual support.
- Reviews the events of the day. *Suggested Guidelines for Managing a Suicide in the Schools*
- Reviews the characteristics of high-risk students (those who seem especially upset or depressed or show other signs of not coping well) and compiles a confidential list of staff observations of distressed students' reactions during the day.
- Announces the wake and funeral arrangements. If possible, make provisions for staff to attend in order to provide support to students and their families funeral services scheduled after regular school hours minimize the disruption of the school schedule. However, if this is not the family's choice, the school should stay open for students who choose not to attend.

Second Day After a Suicide / Death

1. Announce an open meeting for concerned parents. This can be an evening meeting.

2. Meet at the end of the day to discuss staff concerns regarding events of day.

3. Crisis team members and clinical staff continue crisis intervention, answer phone calls of anxious parents, and meet with concerned staff.

4. Principal writes letters to all parents of "high-risk" students reminding them to seek professional evaluation.

5. Outside consultant and school staff conduct an evening meeting of concerned parents. The consultants, making use of their "expert" status, urge the families of those students who are not coping well to pursue evaluations at one of the public or private mental health agencies listed in their area. Crisis team members and clinical staff are available to privately answer parents' specific concerns about why some children were identified as "at risk" or any other concerns parents may be having. Clinical staff meets for half an hour following, parent meetings to discuss meeting.

Third Day After a Suicide / Death

1. "School / Community Steering Committee" is formed and generates plans for a meeting involving interested community leaders to discuss a community-wide response to the needs of the youth of the town or area. Take into consideration leisure time activities, alternatives to school suspension, incarcerated and minority youths' concerns, and runaways.

2. "Frontline" staff who have been dealing directly with the crisis meet with a consultant for the expression of feelings and mutual support. (This is a *very* necessary ingredient as "burn-out" can be a problem with crisis situations.) Also, former losses of "frontline" staff may come to current awareness. A mental health consultant is very useful to prevent staff burnout.

Some Additional Suggestions

These suggestions should be addressed soon after the youth's death has been announced.

- Assign one school authority to interact with the media. A fine line needs to be walked to ensure honest reporting of the student's involvement in the school. Never speculate as to why the student committed suicide. Focus on the positive steps of the school's postvention plan to help students through the crisis. Also emphasize resources for help.
- The principal, along with a selected member from the crisis team, should visit the victim's family at home. In addition to the expressions of sympathy and support, explain the school's plan for helping the grieving survivors. The family may assist in identifying friends and siblings in schools who may need assistance. Advice can be given with regard to contacts by the media.
- This can be a time to offer assistance in retrieving their child's personal belongings from lockers, etc. Parents may wish to do this in privacy or have someone else do it for them.
- Memorials. One of the more delicate issues a school faces after a suicide is to decide on appropriate commemorative activities. **All efforts must be made to avoid glamorizing or sensationalizing a suicide.** Things such as dedicating athletic events or establishing permanent memorials have the potential of providing an invitation to consider suicide. Grieving, students may be very insistent that the memory of their

deceased friend be honored. These energies are best channeled into constructive projects that help the living. Schools need to create policies that provide guidelines for commemorative activities for any student who dies for any reason.

- **Avoid holding large school assemblies and public address announcements** about any suicide. There is evidence to the effect that these actions tend to memorialize and romanticize the suicides, thus extending the problem. It is better to address the situation on a smaller scale, for example, in drop-in locations and in homeroom discussions with trained personnel.

Long-Term Effects and Follow-Up

The aftermath of a suicide can be one of the most stressful and painful events a school will ever experience. The intense phase of the crisis may last only a few days or weeks, but some effects are ongoing for a year or more. Schools must be sensitive to how special events and the anniversary of the suicide may reawaken distress. Postvention efforts may need to be reintroduced.

Remember, prevention efforts are important but do not substitute for postvention work. It is not appropriate to introduce new prevention initiatives until well after the crisis.

Managing a suicidal crisis may leave a school a stronger, more resilient, and more caring system. Everyone can learn and grow from such an experience.

Source: Adapted from Solanto, Joseph. "Days After: A School's Response in the Aftermath of Sudden Adolescent Death" in Teenage Suicide Prevention Intervention Response. Cosad and Four Winds Hospital. C1984. Pb. 10-12 and Carpussi.David. Adolescent Suicide, Awareness Prevention Crisis Response. Portland State University, Oregon. 1994.

Two or more suicides occurring closely in time and/or in a restricted geographic area have occurred throughout human history. As noted in the first book on the subject, *Suicide Clusters* by Loren Coleman, it was during the fourth century B.C. that the earliest historical account of a suicide cluster was recorded from Miletus when groups of young Greek women began killing themselves. However, it was not until the end of this millennium that the waves of teen suicide clusters gained the attention of parents, community leaders, researchers, and the media. Suicide clusters are a continuing problem today.

The Centers for Disease Control wrote in a 1989 study that "statistical analysis of national mortality data indicates that clusters of completed suicide occur predominantly among adolescents and young adults, and that such clusters account for approximately 1%-5% of all suicides in this age group."

Suicide clusters are thought by many, also according to the CDC. Coleman, and others, to occur through a process of "contagion." This "copycatting" of reported suicidal behavior, transmitted through word-of-mouth in a community or school, or via the media, may lead to further suicides or suicide attempts. As the CDC observed, "a great deal of anecdotal evidence suggests that, in any given suicide cluster, suicides occurring later in the cluster often appear to have been influenced by suicides occurring earlier in the cluster. Ecologic evidence also suggests that exposure of the general population to suicide through television may increase the risk of suicide for certain susceptible individuals..."

In their most recent discussion of suicide clusters, the CDC concluded: "Evidence suggests that the effect of contagion is not confined to suicides occurring in discrete geographic areas. In particular, non-fictional newspaper and television coverage of suicide has been associated with a statistically significant excess of suicides. The effect of contagion appears to be strongest among adolescents, and several well publicized "clusters" among, young persons have occurred."

In April 1994, the CDC published a series of recommendations and guidelines for dealing with suicide clusters, contagion, and the media, authored by Patrick W. O'Carroll, M.D., M.P.H. Office of the Director. Office of Program Support, and Lloyd B. Potter, Ph.D. M.P.H. National Center for Injury Prevention and Control.

- ❑ **Watch** for a series of similar suicides in terms of age and sex of the individual victims, methods used, closeness in time, schools attended, peer groupings, and residences. If a pattern develops, you probably have a suicide cluster in your community.

- ❑ **Identify** the close friends and associates of the cluster victims. Whether or not a true suicide pact (one in which a group consciously agrees to mutually commit suicide) exists, all of the intimates of the person who committed suicide are at high risk.

- ❑ **Encourage,** in a supportive fashion, the families of any teens who commit suicide to hold sittings, wakes, and funerals during after school hours or on weekends. Teens should not be given the message they can stop the world if they kill themselves. Grief work is important, but is best supported during non-school times.

- ❑ **Avoid** holding large school assemblies and public address announcements about a suicide. There is evidence to the effect that these actions tend to memorialize and romanticize the suicides, thus extending the problem. It is better to address the situation on a smaller scale, for example in drop in locations and in homeroom discussions with trained personnel.

- ❑ **Involve** all segments of the community, including the local press, downplaying the Suicides. The reports of the suicides should not be graphic or sensationalized. Sensationalized media reporting about suicide has been shown to increase the risk of contagion or "copycat" suicide and/or suicide clusters.

Suicide has for many years been a taboo subject. This shroud of secrecy, has helped foster misleading myths about suicide and made constructive, informed community discussions about suicide more difficult. However, public discussion of suicide in the media must also consider research findings about media coverage and contagion that highlight the need for considerable caution and care.

The key issue is the potentially harmful impact of a prominent media suicide story on those in the community who are already vulnerable. The specific concern arises from research evidence that prominent news stories about suicide have been followed by an increase in suicides in areas impacted by these stories. Adolescents and young adults appear to be particularly susceptible to repetitive coverage of suicide stories in the media which can strengthen their preoccupation with self-harm and suicide. The challenge is to ensure that any public discussion of suicide promotes the safety of those at risk. A key aim is to emphasize the help and support that is available in the community for any person struggling with painful circumstances in their life.

What Evidence is There for this Concern?

Studies indicating the need for care and caution in media reporting of suicide have emerged from the United States, Europe, and Australia. David Phillips and his colleagues from the University of California at San Diego have characterized concerns about contagion as "the Werther effect," named after Goethe's fictional hero whose suicide was seen by some contemporaries as instrumental in precipitating subsequent suicidal behavior. Their review of literature on this subject identified substantial circumstantial evidence that prominently publicized news stories about suicide were followed by a rise in completed suicides in communities likely to have been impacted by the report. Similar findings have been reported by Columbia University's Madelyn Gould and Riaz Hassan at Flinders University, Adelaide.

Much of this research is based on measuring numbers of suicides immediately following a media story. There is no way of knowing how many of those individuals who died by suicide immediately following the story read the account or were influenced by it. However, the repeated finding that prominent media stories have often been followed by significant increases in suicides highlights a problem that cannot be lightly dismissed.

There is also some evidence that changes in media policy can make a difference. One Austrian study indicated that changes in media policy could have beneficial effects. A 1987 media

policy decision to discontinue reporting subway suicide in Vienna was followed by a subsequent reduction in these deaths, even though suicide rates from other means remained relatively unchanged.

Some Guidelines to Consider

Stories about suicide are sometimes newsworthy and will be reported. Few want to return to a situation where suicide is considered a taboo topic that cannot be discussed. How we talk about it is what deserves careful attention. The Center for Disease Control in Atlanta, USA, commissioned a special working party to address this issue and published its own recommendations in 1994. These guidelines and those proposed by other in the field suggest that authors of any media story on suicide, need to consider its potential impact on people in their audience or readership who may be vulnerable to suicidal behavior.

Key Themes

- Simplistic cause and effect relationships such as, "study pressures lead to teenager's suicide," convey a misleading impression.
- Acknowledge the pain and suffering behind any life story ending in suicide. Suicide is a tragic, potentially avoidable outcome arising from troubled circumstances. Consider the impact of the story on the grief of those mourning this loss or on those whose grief from earlier losses may be aroused.
- Avoid idealizing suicide or romanticizing people who take their own lives that might present them as possible role models to be imitated.
- Avoid giving suicide stories undue prominence, sensational treatment or repetitive attention. Also avoid providing detailed descriptions of methods of the suicide.
- Feature stories about people who adopted life-affirming options. Media stories can provide role model alternatives to readers by featuring stories of people who found a way through their suicidal crisis.
- Publicize sources of help. Ensure that a story always features information about where people can receive help. This works to ensure that people at risk, or those concerned about friends at risk have somewhere to go immediately with their concerns.
- Above all, public discussion about suicide needs to emphasize that suicide can be prevented and that help is available to those in the community seeking to find a way through painful circumstances in their lives.

Source: Bruce Turley MA, is a Counseling Psychologist and Director of Lifeline Australia Youth Suicide Prevention Project, a national network of 42 crisis lines based in Melbourne, Australia.

Issues to Address in the Crisis / Suicide Protocol

1. Whom within the school system needs to be notified when a student is suicidal? Whom do the students, PEP (Peer Education Program) students report to? Whom do teachers and staff report to?

2. What are the rules about confidentiality? Are school staff allowed to talk to each other about student's problems?

3. When are the parents contacted? At what point in the process? Who contacts the parents?

4. Who makes the calls to the crisis team, police, ambulance? When are each of these agencies involved?

5. Will there be mental health workers on campus and if so, when do they become involved?

6. Will there be a group or individual coordinating all of these activities, to make sure that everything is done?

7. Where on the school premises would be a safe place to keep a suicidal student, while you are waiting for crisis/police/ambulance etc?

8. Where can the student be interviewed privately by a crisis worker?
Has someplace been designated as an interview room?

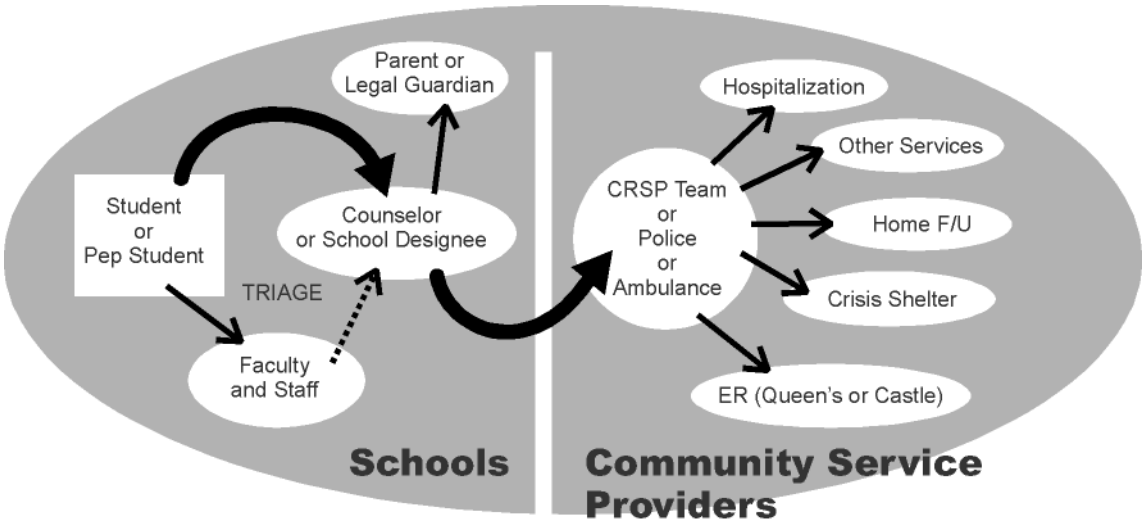
9. What happens when a student returns to school from a suicide attempt? Will there be any follow up by school personnel? Who will do the follow up?

10. What is the school policy about picking up their child and taking them to services on their oven, rather than the crisis team or ambulance escorting them to the ER?

11. What is the school policy, if parents refuse services for their child?

Crisis Response Model

The following is a basic crisis response model. Each site and situation may call for the development and presentation of its own model.



SECTION IV.

- Preparing a Gatekeeper Training
- Gatekeeper Workshop Outline

Using Your Gatekeeper Manual

Your manual is designed to be used as an integral part of a youth suicide prevention gatekeeper training program. It is meant to support individuals who wish to share this information with general audiences as well as those who simply want the information to use in their personal work with youth. Hopefully, public health education on what to do to help a suicidal person will ultimately decrease the number of young people we lose to suicide.

Time Frames for Your Presentations

Suggested outlines are included in the manual for one, one and a half, and two hour programs. Each facilitator will have to carefully plan the program according to time available. It is best to schedule your session separate from meetings in which a lot of other business must take place. It is important that you have enough time to be sensitive to the group. While presenting this program in one hour is a real challenge, it is easy to expand it. Suicide prevention programs are relatively new and people are anxious to talk about the subject. Be sure to allow a minimum of five to ten minutes within and at the end of your scheduled presentation for questions and answers. Also, plan to be available for at least 20-30 minutes after your presentation to talk with anyone wanting some one-on-one discussion. Talking with others is a necessary part of facilitating this program.

Scheduling Your Presentations

Remember this is a prevention program. If your community has recently experienced a suicide, it may not be the best time to offer your program. Information on crisis intervention and postvention would be more appropriate. It is important to recognize your own limits. You have suicide prevention information you can share, but you must be very careful not to prevent yourself as a suicide expert (unless, you are one).

Staff Requirements

When talking about a sensitive topic, it is always a good idea to have at least one other informed person with you to be the extra set of eyes and ears. You want to avoid having someone in the audience who is actively thinking about suicide leave the room without at least a chance to open up and ask a question. This other person could be another trained gatekeeper or a community member familiar with referral sources.

Be Prepared to Make Referrals

The fact that you are willing to talk about suicide, a subject not widely discussed, may inspire

others to share their thoughts and feelings. Several people in your audience will have had some personal experience with suicidal behavior in someone they know, if not themselves. As groups facilitator, you may very well have the opportunity to refer someone at current risk for help, or help someone who knows of another at risk. This is your responsibility. If you do not know of referral resources in the community in which you are speaking, make sure you have someone in your audience who does know. Remember that your job is to help others recognize and refer people in trouble for help. It is not to treat suicidal people. Suicidal behavior is very complex. You are not expected to be the mental health expert.

What to Expect

Expect to have strong emotions stirred in yourself. Monitor them, understand that the very nature of suicide is complicated. It is important that you take care of yourself, realize that suicides will still happen in your community, but preventing even one is something to celebrate. Helping others to even begin to be talk about suicide is a huge step.

Getting Your "Stuff" Together

Materials and resources needed for your session include:

- Overhead projector
- VCR and Monitor
- Overhead transparencies
- Copies of the Gatekeeper Manual or training materials
- Name tags
- Agency Resources and Referral procedures
- Suicide Prevention References and Literature
- Snacks and Beverages - optional, but nice

Start on Time

Starting late will put pressure on you, the facilitator, to condense really important and sensitive information. One suggestion is to schedule an extra ten or fifteen minutes before the actual training starts, to allow people to mingle, grab a snack, etc. The length of these sessions does not lend itself to breaking in the middle.

Take the Time to Prepare Yourself

Suicide prevention workshops do not lend themselves to being done "on the fly." The topic is sensitive. Be sure to read over this entire manual and review the key elements before each session. Take the time to practice the sections with which you think you might have difficulty. Be rested and prepared to stay focused on the topic and the participants fully. The program is fast paced and requires a lot of energy on the part of the facilitator. Above all else, be hopeful

and positive.

Remember Your Role as Facilitator

While you need to be familiar with the material, you do not have to be an "expert" nor should you present yourself as one. The more comfortable you are with the information and the flow of the session, the more effective you will be. Your role is to share the information and facilitate the discussion and question and answer period. It is perfectly acceptable to say "I don't know" in response to questions beyond your ability to answer. Ask the person to write the questions down with their name and number and offer to get back to them, or at the very least prepare yourself to answer it the next time it comes up. Do no under any circumstances take on the role of a mental health expert. The scope of this program does not require that expertise.

The Details Are Up to You

The outlines suggest time frames for your presentations. The information you would like to present will need to be tailored to your target audience. Feel free to pick and choose any of the elements you think your audience needs. Highlight the importance of critical areas and the need for a comprehensive approach to prevention. **It is up to you to stay focused and add detail depending upon the time available to you.**

It is expected that the average community group informational session would be scheduled for 60 to 90 minutes.

Suggested Key Program Elements

1. Welcome and Introductions

   Purpose

   · Establish a comfortable atmosphere

   Process

   · Thank the audience for their interest in a sensitive topic
   · Introduce yourself as a "non-expert" information sharer
   · Introduce the program agenda

2. Myths and Facts
   · Participants will examine some personal beliefs about suicide
   · Baseline information about youth suicide will be established
   · Ask participants what commonly held beliefs might possibly keep people from trying to prevent a suicide.
   · Expect to very briefly discuss at least half of the myths listed. Remind participants that this information is included in their booklet.

3. Recognizing and Understanding How a Young Person Develops Suicidal Thoughts and

Feelings

- Understand that suicide is multi-dimensional
- Recognize many of the risk factors, warning signs, and other clues
- Develop a sense of what a suicidal crisis might look like
- Briefly define the concept of risk factors, warning signs and clues by referring to the selected handouts from the gatekeeper manual.
- Stress that it is almost always the combination of many factors that will cause someone to see suicide as the only solution to their problems.
- Reinforce that almost always there are several clues, but each of us holds a different piece of the puzzle. This is why we need to be educated to talk to each other and to the person who may be suicidal when out gut tells us that he or she is in trouble.
- Mention that the average suicidal crisis period for youth is about two weeks. Sometimes they move very quickly to end their pain. It is important to take action as soon as possible. The earlier the journey to suicide is interrupted, the better.

4. How to Ask About Suicide
   - Show overhead with sample questions (also listed in the booklet).
   - Stress that asking the question will not put the idea of suicide someone's mind.
   - Explain that if the thought of suicide has crossed your mind, they very likely have already thought about it as well.
   - The individual asked about suicide will usually respond with some relief that someone has noticed their pain.
5. Responding to Suicidal Behavior
   - Provide information on what to do and what to avoid
6. Referrals
   - Refer to the list of referral resources in your manual
   - Refer to your school's crisis/suicide referral plan
   - Stress the importance of **never leaving a suicidal youth alone,** even for a minute.
7. Question and Answer Period

Suggested Outline for a One Hour Workshop

This introductory, very basic workshop is specifically designed to increase the participants' general knowledge of suicidal behavior in youth. At the end of the session, participants will be informed about how to recognize suicidal behavior, respond appropriately, and recognize the importance of referring the individual for help. This format relies heavily on the Gatekeeper Manual, which includes more detailed information, that is only briefly touched on in the program.

1. Welcome	5 minutes
2. Myths and Facts About Suicide	5 minutes
3. Risk Factors and Warning Signs	20 minutes
4. Responding to Suicidal Behavior How to Ask About Suicide Getting Help/Making Referrals	20 minutes
5. Questions and Answers	5 minutes
6. Thank You and Closing	5 minutes

Suggested Outline for a Ninety Minute Workshop

This introductory, very basic workshop is specifically designed to increase the participants' knowledge of suicidal behavior in youth. At the end of the session, participants will be informed about how to recognize suicidal behavior, respond appropriately, and the importance of referring the individual for help. This format relies heavily on the Gatekeeper Manual, which includes information mentioned briefly in the program.

1. Welcome	5 minutes
2. Myths and Facts About Suicide	25 minutes
3. Risk factors and Warning Signs	25 minutes
4. Responding to Suicidal Behavior How to Ask About Suicide Getting Help/Making Referrals	25 minutes
5. Postvention: The Aftermath of a Suicide	10 minutes
6. Questions and Answers	10 minutes
7. Thank You and Closing	5 minutes

Suggested Outline for a Two Hour Workshop

This introductory, very basic workshop is specifically designed to increase the participants' knowledge of suicidal behavior in youth. At the end of the session, participants will be informed about how to recognize suicidal behavior, respond appropriately, and the importance of referring the individual for help. This format relies heavily on the Gatekeeper Manual, which includes information mentioned briefly in the program.

1. Welcome	10 minutes
2. Myths and Facts About Suicide	10 minutes
3. Risk Factors and Warning Signs	30 minutes
4. Responding to Suicidal Behavior How to Ask About Suicide Getting Help/Making Referrals	30 minutes
5. Postvention: The Aftermath of a Suicide	20 minutes
6. Questions and Answers	15 minutes
7. Thank You and Closing	5 minutes

SECTION V.

- *Appendix A:*
  Suicide Resource Directory
- *Appendix B:*
  Assessment Tools
- *Appendix C:*
  Developmental Assets
- *Appendix D:*
  Parent Support Materials
- *Appendix E:*
  Suicide Prevention and Information Websites
- *Appendix F:*
  Suggested Reading / Bibliography
- *Appendix G:*
  Case Histories
- *Appendix H:*
  Experiential Learning Activities
- *Appendix I:*
  Ohana Group Activities
- *Appendix J:*
  Cultural Sharing Activities
- *Appendix K:*
  Agenda, Conference Materials, and Notes

Appendix A: Suicide Resource Directory

Crisis Telephone Numbers - Call 911, or "0", or call:

O'ahu Crisis Center - Helping Hands Hawai'i

Crisis Hotline 521-4555
24 hour crisis hotline; anonymous, confidential service; counseling and suicide/crisis assessment; information and referral; staffed by trained volunteers.

Adult & Youth Crisis - 24 hour island-wide outreach services; suicide/homicide/crisis assessment; individualized counseling; linkage to community resources; staffed by mental health professionals

Survivors of Suicide (SOS) - Support group for survivors of suicide and for people who have lost a loved one to suicide; led by trained group facilitators; meets every Tuesday; other SOS services available upon request.

Hawai'i Crisis Center - Helping Hands Hawai'i

Hilo 935-3393
Kona 323-7444

Kaua'i

Kaua'i Family Guidance Center (M-F ,7:45 AM - 4:30 PM) 247-3883
Wilcox Hospital Emergency Room (after hours) 245-1010

Maui, Moloka'i, Lanai

Helpline ..... 244-7407 / 553-3311
..... 1 (800) 887-7999
Maui Kokua Services 244-7407

Military

Army Community Service - (After-Hours Helpline) 656-1900
Provides information and crisis assistance for all military personnel, their dependents, and retirees.

O'ahu Emergency Rooms with Psychiatric Services

Queen's Medical Center ER: 547-4311
Castle Medical Center ER: 263-5164

Family Guidance Centers

Helps children ages up to 18 and their families or caregivers when children have emotional, behavioral, or social adjustment difficulties. Includes: prevention education, screening, identification of problems, treatment (counseling), information and referral and crisis intervention. Open from 7:45 a.m. to 4:30 p.m.

Oahu

Central 435-5900
Leeward 692-7700
Diamond Head 733-9393

Kalihi-Palama 832-3792
Windward 233-3770

Hawai'i

Hawai'i 974-4300

Kaua'i

Kaua'i 274-3194

Maui

Maui 877-5037
Moloka'i 567-5067
Lana'i .....

The National "YOUTH" Crisis Helpline: 1-800-999-9999

The National Crisis Helpline: 1-800-784-7433

National Resource Center for Suicide Prevention & Aftercare 1-404-256-9797

Risk Factors Checklist For Suicide

- ☐ Previous suicide attempt

Depression

- ☐ Change in personality
- ☐ Depressed or irritable mood
- ☐ Insomnia or hypersomnia
- ☐ Lack of energy
- ☐ Increase or decrease in appetite
- ☐ Decreased self esteem
- ☐ Feelings of hopelessness
- ☐ Anhedonia - inability to enjoy things
- ☐ Social withdrawl
- ☐ Decreased cognitive ability or decreased concentration
- ☐ Negative thinking

Other Psychiatric Disorder

- ☐ Bipolar disorder
- ☐ Conduct disorder
- ☐ Eating disorder
- ☐ Panic disorder
- ☐ Obsessive compulsive disorder
- ☐ Schizophrenia
- ☐ Personality disorder

Other Risk Factors

- ☐ Drug or alcohol abuse
- ☐ Perfectionistic personality traits
- ☐ Impulsive/aggressive personality traits
- ☐ Poor coping skills
- ☐ Poor problem solving skills
- ☐ History of physical or sexual abuse
- ☐ Gay or lesbian issues
- ☐ Poor family support
- ☐ Suicide /suicide attempt of a friend or family member

Stresses

- ☐ Recent breakup of relationship
- ☐ Recent fight or argument with family member, girlfriend/boyfriend
- ☐ Disciplinary or legal action
- ☐ Recent or impending academic failure
- ☐ Death or loss of close family member or friend

Warning Signs

- ☐ Preoccupation with death and dying
- ☐ Verbal statements about death
- ☐ Written statements about death
- ☐ Themes of death in art or writing
- ☐ Engaging in high risk behaviors
- ☐ Giving away possessions
- ☐ Putting affairs in order
- ☐ Saying goodbye to loved ones
- ☐ Sudden lifting of mood after period of intense depression
- ☐ Gathering materials for suicide

Thoughts and Behaviors

- ☐ Suicidal ideation
- ☐ Suicide plan
- ☐ A method for suicide
- ☐ Lethal method
- ☐ Accessible plan
- ☐ Steps to carry out the plan
- ☐ Agitation
- ☐ Poor impulse control
- ☐ Intoxicated with alcohol or drugs
- ☐ Not able to contract not to harm themselves

The S.L.A.P. Suicide Assessment Scale

Development of a plan of suicide is a major indicator of the seriousness of suicidal ideas. A well-developed plan can be measured by the following factors, referred to as the S.L.A.P. Scale. This is not a foolproof method of assessing risk, but it can be a helpful tool for individuals faced with having to gather information from a potentially suicidal person. This kind of information is very valuable to a crisis worker.

S **How SPECIFIC are the details of the plan?**

- The greater the specificity, the higher the risk.
- Adolescents may, however, be impulsive and act without a plan.

L **How LETHAL is the intended method?**

- The more lethal, the higher the risk
- How reversible are the means?
- How intent is the adolescent on dying?
- Adolescents who have difficulty with the concept of the finality of death may use a more lethal means than they intend.

A **What is the AVAILABILITY of the proposed method?**

- The more available the means**,** the higher the risk.

P **What is the PROXIMITY to helping resources?**

- The greater the distance from rescue, the higher the risk.
- Proximity is measured in physical, geographical, and emotional terms

Source: Developed by Miller (1986)

Lethality Assessment

These signs, seen even once, represent a very high lethality

- ☐ Giving away of personal possessions
- ☐ Discussion and/or making of suicide plans
- ☐ Discussion and/or gathering of suicide methods
- ☐ Previous suicide attempts or gestures
- ☐ Scratching, marking body, other self-destruction
- ☐ Death themes through outspoken, written, and art works
- ☐ Expression of hopelessness, helplessness, and anger at self and the world
- ☐ Use of dark, heavy, slashing lines, unconnected bodies in artwork and doodling
- ☐ Statements that family and friends would not miss them
- ☐ Recent loss through death
- ☐ Recent loss through Suicide
- ☐ Sudden positive behavior change following a period of depression

Source: Basic Assessment tools reprinted here through the courtesy of Suicide Prevention Center, Dayton, Ohio

Youth Suicide Knowledge Pre/Post Test

	True	False
1. Young people who talk about suicide never attempt or complete suicide.	❑	❑
2. Suicide is not hereditary.	❑	❑
3. Once a person is intent on suicide, there is no way of stopping them.	❑	❑
4. All suicidal young people are depressed.	❑	❑
5. There is a strong correlation between alcoholism and suicide.	❑	❑
6. Most Suicidal young people are insane or mentally ill.	❑	❑
7. Once a young person is suicidal, they will be suicidal forever.	❑	❑
8. Talking about suicide or asking someone if they feel suicidal will not encourage a suicide attempt.	❑	❑
9. Suicide is much more common in young people from higher or lower socioeconomic groups.	❑	❑
10. You should not keep a note unopened or unread if you suspect harm.	❑	❑
11. Most attempted or completed suicides happen without warning signs.	❑	❑
12. People who threaten or attempt suicide are merely seeking attention.	❑	❑
13. Suicide is painless.	❑	❑
14. A sudden improvement in the mental state of an attempter following a suicidal crisis signifies that the suicide risk is over.	❑	❑
15. Suicidal young people can help themselves.	❑	❑

	True	False
16. The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.	❑	❑
17. Most suicidal young people seek or ask for help with their problems.	❑	❑
18. Suicidal young people are always angry when someone intervenes and then will resent that person afterwards.	❑	❑
19. Every death is preventable.	❑	❑
20. If a person attempts suicide and survives, he or she will never make another attempt.	❑	❑

Youth Suicide Knowledge Pre/Post Test Answers

	True	False
1. Young people who talk about suicide never attempt or complete suicide.	❑	☑
2. Suicide is not hereditary.	☑	❑
3. Once a person is intent on suicide, there is no way of stopping them.	❑	☑
4. All suicidal young people are depressed.	❑	☑
5. There is a strong correlation between alcoholism and suicide.	☑	❑
6. Most Suicidal young people are insane or mentally ill.	❑	☑
7. Once a young person is suicidal, they will be suicidal forever.	❑	☑
8. Talking about suicide or asking someone if they feel suicidal will not encourage a suicide attempt.	☑	❑
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11. Most attempted or completed suicides happen without warning signs.	❑	☑
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13. Suicide is painless.	❑	☑
14. A sudden improvement in the mental state of an attempter following a suicidal crisis signifies that the suicide risk is over.	❑	☑
15. Suicidal young people can help themselves.	☑	❑

	True	False
16. The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.	❑	☑
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18. Suicidal young people are always angry when someone intervenes and then will resent that person afterwards.	☑	❑
19. Every death is preventable.	❑	☑
20. If a person attempts suicide and survives, he or she will never make another attempt.	❑	☑

Appendix C: Developmental Assets

External Assets

Support

1. **Family Support** – Family life provides high levels of love and support
2. **Positive Family Communication** – Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).
3. **Other Adult Relationships** – Young person receives support from three or more nonparent adults.
4. **Caring Neighborhood** – Young person experiences caring neighbors.
5. **Caring School Climate** – School provides a caring, encouraging environment.
6. **Parent Involvement in Schooling** – Parent(s) are actively involved in helping young person succeed in school.

Empowerment

7. **Community Values Youth** – Young person perceives that adults in the community value youth.
8. **Youth as Resources** – Young people are given useful roles in the community.
9. **Service to Others** – Young person serves in the community one hour or more per week.
10. **Safety** – Young person feels safe at home, at school, and in the neighborhood.

Boundaries and Expectations

11. **Family Boundaries** – Family has clear rules and consequences and monitors the young person's whereabouts.
12. **School Boundaries** – School provides clear rules and consequences.
13. **Neighborhood Boundaries** – Neighbors take responsibility for monitoring young people's behavior.
14. **Adult Role Models** – Parent(s) and other adults model positive, responsible behavior.
15. **Positive Peer Influence** – Young person's best friends model responsible behavior.
16. **High Expectations** – Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time

17. **Creative Activities** – Young person spends three or more hours per week in lessons or practice.
18. **Youth Programs** – Young person spends three or more hours per week in sports, clubs or organizations at school and/or in the community.
19. **Religious Community** – Young person spends one or more hours per week in activities in a religious institution.
20. **Time at Home** – Young person is out with friends "with nothing special to do" two or fewer nights per week.

Internal Assets

Commitment to Learning

21. **Achievement Motivation** – Young person is motivated to do well in school
22. **School Engagement** – Young person is actively engaged in learning.
23. **Homework** – Young person reports doing at least one hour of homework every school day.
24. **Bonding to School** – Young person cares about her or his school.
25. Reading for Pleasure – Young person reads for pleasure three or more hours per week.

Positive Values

26. **Caring** – Young person places high value on helping other people
27. Equality and Social Justice – Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity** – Young person acts on convictions and stands up for her or his beliefs.
29. **Honesty** – Young person "tells the truth even when it is not easy"
30. Responsibility – Young person accepts and takes personal responsibility.
31. **Restraint** – Young person believes it is important not to be sexually active or to use alcohol or other drugs.

Social

32. **Planning and Decision Making** – Young person has empathy, sensitivity, and friendship skills.
33. **Cultural Competence** – Young person has knowledge or and comfort with people of different cultural/racial/ethnic backgrounds.
34. **Resistance Skills** – Young person can resist negative peer pressure and dangerous situations.

35. **Peaceful Conflict Resolution** – Young person seeks to resolve conflict nonviolently.

Positive

37. **Personal Power** – Young person feels he or she has control over "things that happen to me."
38. **Self-Esteem** – Young person reports having a high self-esteem.
39. **Sense of Purpose** – Young person reports that "my life has a purpose"
40. **Positive View of Personal Future** – Young person is optimistic about her or his personal future.

Source: Journal of School Health, March 1999, Vol. 69, No. 3, Copyright 1997 by Earch Institute, 700 S. Third Street, Suite 210, Minneapolis, MN 55415.

Five Minutes Can Save a Life

A Three Step Intervention for Parents of Suicidal Adolescents

1. Inform the parents that their adolescent is at risk for suicide and why you think so. For example, if you are working with an adolescent who is known to have made one attempt by overdose, it is important to inform the parent or caretaker that "Adolescents who have made a suicide attempt are at risk for another attempt. One attempt is a very strong risk factor for another."

2. Tell parents or caretakers that they can reduce the risk of suicide by removing firearms from the house. "The risk of suicide doubles if a firearm is in the house, even if the firearm is locked up." Anything that will help parents or caretakers understand the importance of removing access to a firearm or other lethal means is extremely important. Two thirds of Hawai'i's youth suicides are committed with a firearm. Tell parents this even if they don't presently own a firearm. It is important information for all parents.

3. Educate parents about different ways to dispose of, or at the very least, limit access to firearms. Officers from local police departments, sheriff's offices, or state police barracks are willing to discuss the disposal of firearms. For more information on firearm disposal, see "Frequently asked Questions," on pages 41-44 of this manual. This will inform you, as gatekeepers, on what to expect in terms of policies and procedures for either removing, and storing or disposing of firearms.

This intervention saves lives. It is a very important gatekeeping function. It may**,** very well mean the difference between life and death for an adolescent.

Supporting Parents in a Suicidal Crisis

***Family Support* is Critical**

When an adolescent experiences a suicidal crisis, the whole family is in crisis. If at all possible, it is important to reach out to the family for two very important reasons:

1. The family may very well be left without professional support or guidance in what is often a state of acute personal shock and distress. Many people do not seek help - they don't know where to turn.

2. Informed parents are probably the most valuable prevention resource available to the suicidal adolescent.

The goal of extending support to the parents is to help get them to a place where they can intervene appropriately to prevent this young person from attempting suicide again. Remember, a prior attempt is the strongest predictor of suicide. Education and information are vitally important to family members and close friends who find themselves in a position to observe the at-risk individual. The importance of removing lethal means from the home of a vulnerable youth must be stressed. In the event of another potential suicidal crisis, parents or guardians need to know how, when and where they can call for help. They also need to know that they do not have to carry the entire responsibility for keeping their loved one alive.

It is important to identify, in advance of a crisis, who in your area can provide support and assistance to parents. Even a small amount of support and encouragement can make an enormous difference. It might be just the thing that allows the parent(s) to deal with an overwhelming situation for a little while longer.

What Parents May Be Thinking and Feeling

- "Nothing I thought - or knew about my child - is true, nor is it what I thought it was."
- Paralyzed, afraid, ashamed, angry-very angry, belligerent (understand that behind these feelings is terror)

Supporting Parents in a Suicidal Crisis

- Total denial
- Strong desire for "normalcy"

How Gatekeepers Can be Helpful

- "Just be there" (through the immediate crisis)
- Reflective listening
- Provide information and referrals
- Explain the importance of removing lethal means from the hot-ne and information on

how to do that
- Model limit setting and self care

Parents May Need Support in Several of the Following Ways

- Overcoming their emotional reactions; normal reactions such as paralyzing anxiety, a sense of helplessness, and/or denial
- Support in recognizing the necessity of finding professional help
- Recognition, not for their weaknesses, but for their key role in helping their child recover
- Acceptance of the seriousness of the situation

- Accepting, responsibility appropriately and in understanding their limits
- Identification of coping, mechanisms and in identification of their own support system
- Understanding, the process of how to remove firearms from their environment
- Establishing some hope

Above All Else

- Emphasize safety, strongly suggest removing all lethal means from the household
- Avoid judgment, blaming
- Acknowledge the impact, the fear
- Support any acceptance of responsibility
- Assist parents to access, obtain, or arrange for appropriate help
- Stress that parental involvement is really, REALLY important

Things You Can Ask - or Say - Once the Immediate Crisis Has Passed

- How can I help?
- How are you coping?
- Who can you talk to? How are you in touch with these people? Would it help if I called them for you? (sometimes just picking up the phone is more than they can do for themselves)
- “I can appreciate how this has turned your world upside down. It is great that you have been willing to get help. None of us can do this alone.”
- “How have we (professionals) been helpful? What has not been helpful? What could we do better?

Special Features of a Suicide Bereavement

A. Feelings are Overwhelming

- **Shock:** Sudden unanticipated loss
- **Disbelief:** How could things have been so bad that suicide was chosen?

- **Guilt:** How did I contribute to this? Could I have done something to prevent it?
  Shame: What do I tell people? Do I have to tell them at all?
- **Blame:** School, spouse, parent, employer, therapist (suicide malpractice is the number-one claim brought against psychiatrists, psychologists, social workers, and nurses).
- **Puzzlement:** How could he do this to me? To our family? I just don't understand etc.
- **Anger:** What a stupid thing to do! Why didn't he talk to me? He didn't have to do this.

B. Usually a Combination of Individual Psychotherapy and Group Care is Most Helpful

- Time limited, individual therapy often very helpful in sorting through the above list of feelings, events prior to death, questions about the mental health of the deceased.
- Group support comes because members identify with survivor and allow those strong emotions and feelings to be expressed.
- The grieving person sees others who got through this experience and feels understood.
- Close bonding occurs through shared experience.
- Ideas are shared on how to deal with everything from legal issues, telling others, to dealing with holidays and anniversaries.
- Group therapist or facilitator recognizes disturbed reactions, depressions, etc.

When a Family Member Completes a Suicide, What Does One Say / Do?

- Say something!
- I'm sorry.
- Acknowledge the loss, send a note, a card, a list of community, resources.
- Share a memory. Use the name of the deceased.

Grieving: It's Okay

It's Okay to Grieve

The death of a loved one by suicide is a reluctant and drastic amputation, without any anesthesia. The pain cannot be described, and no scale can measure the loss. We despise the truth that the death cannot be reversed. Suicide survivors will be impacted in different ways and at different times. Many report that the process of grieving takes much longer than "normally" expected. One reason is that they may never arrive at an acceptable explanation. Shock, denial, guilt, intense anger, loneliness, and regret are among many emotions described by survivors. It is important to support survivors through their grief process. It goes without saying that it is okay to grieve.

It's Okay to Cry

Tears release the flood of sorrow, of missing and of love. Tears relieve the brute force of hurting, enabling us to "level off" and continue our cruise along the stream of life. It's okay to cry.

It's Okay to Heal

We do not need to "prove" we loved him or her. As the months pass, we are slowly able to move around with less outward grieving each day. We need not feel "guilty," for this is not an indication that we love less. It means that, although we don't like it, we are learning to accept death. It's a healthy sign of healing. It's okay to heal.

It's Okay to Laugh

Laughter is not a sign of "less" grief. Laughter is not a sign of "less" love. It's a sign that many of our thoughts and memories are happy ones. It's a sign that we know our memories are happy ones. It's a sign that we know our dear one would have us laugh again. It's okay to laugh.

Grief - If We Avoid It, Will It Go Away?

Grief is as old as mankind but is one of the most neglected of human problems. As we become aware of this neglect, we come to realize the enormous cost that it has been to the individual, to the families, and to society, in terms of pain and suffering because we have neglected the healing of grief. Some individuals exhibit evidence of "working through" their grief process in more obvious ways than others. Achieving resolution to a suicidal death is not a universal process. It is different for everyone. Grief doesn't go away, but it changes and healing does happen.

Most grieving people find it essential to have at least one person who will allow them/give them permission to grieve. Some people can turn to a friend or to a family member. Some find

a support group very helpful as they work through their grief. Dealing appropriately with grief is important in helping to preserve healthy individuals and nurturing families. You can postpone grief, but you cannot avoid it. As other stresses come along, one becomes less able to cope if one has other unresolved grief. It requires a great deal of energy to avoid grief and robs one of energy for creative expression in relating to other people and in living a fulfilling life. It limits one's life potential.

Suppressing grief keeps one in a continual state of stress and shock, unable to move from it. The body feels the effects of it in ailments. Emotional life suffers, marriages, friendships, and other relationships suffer. Spiritual life suffers. We say that the person is "Stuck in grief." When a person faces his grief, allows his feeling to come, speaks of his grief, allows its expression, it is then that the focus is to move from death and dying and to promote life and living.

*Source: CD-ROM. Team Up to Save Lives, What your school should know about preventing youth suicide, brought to you by the University of Illinois at Chicago and funded by Ronald McDonald House Charities, (**McDonald's Resource Center —** 1-800-627-7646).*

Source Adapted from a program for parents developed by Heather Fiske, PhD. At Credit Valley Hospital, Mississauga, ON. Canada.

Appendix E: Suicide Prevention & Information Websites

American Association of Suicidology (AAS)

A United States organization of concerned persons and agencies working in suicide prevention. American Association of Suicidology, Central Office, Suite 310, 4201 Connecticut Avenue, N.W., Washington, D.C., 20008, Phone: (202) 237-2280.Fax:(202) 237-2282. The American Association of Suicidology (AAS) promotes research, public awareness programs, and education and training for professionals and volunteers. In addition, it serves as a national clearinghouse for information on suicide. This site provides things you should know about suicide, membership information, a listing of AAS publications, and conference information. Frequently updated.
http://www.suicidology.org/

American Psychiatric Association (APA)

The American Psychiatric Association is a medical specialty society recognized world-wide. Its 40,500 U.S. and international physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders. American Psychiatric Association. 1400 K Street.. N.W., Washington, DC 20005. Phone: (202)682-6000; Fax: (202)682-6850.
http://www.psych.org/

The American Foundation for Suicide Prevention (AFSP)

The American Foundation For Suicide Prevention is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP. 120 Wall Street, 22nd Floor. New York. NY 10005, Phone: (212)410-1111; Fax: (212)363-6237. This site is very easy to navigate and is updated regularly. It contains some very interesting articles on the subject of suicide and the issues surrounding it.
http://www.afsp.org

Washington Youth Suicide Prevention Program

Washington State youth suicide prevention website with prevention, training, and other resources. Provides links to national organizations and their resources.
http://weber.u.washington.edu/-ysp/

SPAN (Suicide Prevention Advocacy Network)

A U.S. network of persons working to raise national awareness and advocate for a National suicide prevention policy. 5034 Odin's Way, Marietta, Georgia, 30068, Phone: (770)998-8819.
http://www.spanusa.org/

American Academy of Child and Adolescent Psychiatry (AACAP)

A leading national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, or developmental disorders. AACAP, 3615 Wisconsin Ave.. N.W., Washington, D.C. 20016-3007. Phone: (202)966-7300; Fax: (202)966-2891. This site provides public information through fact sheets including one on teen suicide.
http://www.aacap.org/

American Academy of Pediatrics (AAP)
An organization of 55,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. National headquarters at 141 Northwest Point Boulevard, Elk Grove, IL 60007-1098. Phone: (847)228-5005; Fax: (847)228-5097. This site provides family oriented fact sheets including one on adolescent depression and suicide.
http://www.aap.org/

SA / VE — Suicide Awareness \ Voices of Education (SAVE)
Includes a helpful Frequently Asked Questions (FAQ) file, general information on suicide and some common statistics, symptoms of depression, a book list, and much more in **an** easy-to-read format. Frequently updated.
http://www.save.org/

Suicide: Read This First
This site contains conversations and writings for suicidal persons to read and a few simple prevention materials. "It grows out of my 14 years work with online (and telephone) crisis counseling and online support groups on depression and suicide." Includes links as well as lots of helpful information.
http://www.metanoia.org/suicide/

A Comprehensive Approach to Suicide Prevention - Lollie McLain This energetic website jumps at whoever comes near. The take control, feel-good approach to suicide prevention is broadcast with different inspirational posters, humorous brochures, lists of action, and stories. The navigating of the site is tricky at first, but highly creative with the use of dual menu bars.
http://www.lollie.com/suicide.html

International Association for Suicide Prevention (IASP)
An international association of concerned persons and organizations working in suicide prevention. International Association Suicide Prevention, Central Administrative Office. Dr. David Clark, Rush Presbyterian, St. Lukes's Medical Center, Rush University, 1725 West Harrison Street, Suite 955, Chicago, IL, 60612-3824.
USA Email: IASP@aol.com

Suicide Information and Education Centre (SIEC)
Suicide Information and Education Centre (SIEC) is a library and resource center. They do not do crisis intervention or counseling; instead, this site gives recommendations on where to get help, in both Canada and the U.S. Located on this site is a comprehensive list of suicide prevention resources, crisis support information, and links to other helpful suicide prevention sites.
This site was found to be very user friendly and would be very helpful to someone who is thinking about committing Suicide or knows of someone that may be suicidal.
http://www.siec.ca/

The Samaritans - U.S. Mirror Site
A non-religious charity that has been offering emotional support to the suicidal and despairing for over 40 years by phone, visit, and letter. Callers are guaranteed absolute confidentiality and retain the right to make their own decisions including the decision to end their life. The service is available via E-mail, run from Cheltenham, England, and can be reached from anywhere with Internet access. Trained volunteers read and reply to mail once a day, every day of the year.
http://www.samaritans.org.uh/

Suicide Resources on the Internet - Dr. John M. Grohol

Links to helpful mailing lists and common suicidal resources online. Many of these resources come from the Suicide Resources FAQ.

http://www.grohol.com/helpme.htm

Overcoming Depression and Preventing Suicide

State University of New York at Buffalo. This site was originally designed to help students at the State University of New York identify depression, so that they may seek help from the University's Counseling Center. The information here may be helpful to anyone with questions about depression/suicide. General information including symptoms is provided. This site also contains the alt.support.depression FAQ.

http://ub-counseling.buffalo.edu/depression/

Gay Bisexual Male Youth Suicide Studies

Demographic work done on the basis of sexual orientation. These results challenge most established beliefs about the male youth suicide problem in the field of Suicidology. Navigating this site becomes somewhat confusing.

http://www.virtual.com/youthsuicide/

National Institute of Mental Health (NIMH)

Bipolar Disorder
Depression: Effective Treatments are Available
Helpful Facts About Depressive Illnesses
If You're Over 65 and Feeling Depressed...
Plain Talk About Depression
Suicide Facts
Information on specific mental disorders, their diagnosis, and treatment.

http://www.nimh.nih.gov/

National Mental Health Association (NMHA)

The National Mental Health Association is dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research, and service. National Mental Health Association. 1021 Prince Street. Alexandria, VA 22314-2971. Phone: (703)684-7722; Fax: (703)684-5968.

http://www.nmha.org/

Centers for Disease Control and Prevention (CDC)

The CDC is an agency of the U.S. Department of Health and Human Services. In addition to health statistics, this website provides access to publications, health information, and funding announcements. Centers for Disease Prevention and Control, 1600 Clifton Road, NE, Atlanta, GA 3O333. Phone: (404)639-3311.

http://www.cdc.gov/

Self-Injury Page - Llama Central

This page comes out of the author's own experience with self-mutilation. It contains frequently asked questions about self-injury, the bodies-under-siege mailing list, and a comprehensive review of treatment modalities by theoretical orientation. Information is presented in a very organized manner.

http://www.palace.net/-llama/psych/injury.html

KidsHealth.org

A website for children's health information sponsored by the American Medical Association and the Nemours Foundation. Provides parents with children's health information on such topics as childhood infection, emergencies and first aid, safety and injury prevention, child development, and understanding and preventing teen suicide.

http://www.KidsHealth.org/

Light for Life Foundation of America

Provides information on the Yellow Ribbon Program for preventing youth suicide. Also included are suicide facts and statistics. Frequently updated.

http://www.yellowribbon.org/

Suicide Prevention Understanding Depression

Created by the McKinley Health Center at the University of Illinois, this site provides information on depression. This helpful information may be used to define what causes the problems and it also gives warning signs to look out for. The content is very useful in providing a basic understanding of causes and solutions of this specific problem.

http://www.odos.uiuc.edu/Counseling_Center/brochure.htm

Depression

Depression.com - NetHealth

Depression.com is a first stop and a gateway to information about depression on the Internet. Based on a large and easily accessible online database, the editorial staff of Depression.com screens the latest news and research, reviews the dozens of depression-related sites in cyberspace, and provides an innovative, interactive forum for people who deal with it. Also provides quizzes and numerous topics filled with information about depression.

http://depression.com/

Beyond the Blues

An informative website that provides all the basic information on diagnosis, cause, treatment, and other topics dealing with Borderline Personality Disorder, Depression, Bipolar Disorder, and Codependency. Helpful links are included for each topic as well.

http://www.ssimicro.com/-chers/btb

Depression and Mental Health Sources on the Internet

This site is basically a listing of resources available online for depression. In addition, there are some unique contributions like the Beck Depression Inventory and the best/worst things to say to someone who's depressed.

http://stripe.Colorado.EDU/-judy/depression/

National Foundation for Depressive Illness, Inc.

The National Foundation for Depressive Illness (NAFDI) provides public and professional information about Affective Disorders, the availability of treatment, and the need for further research. The Foundation is committed to an extensive, ongoing public information campaign addressed to this pervasive, costly, and hidden national emergency. This site provides an overview of depression as well as information on the Foundation.

http://www.depression.org/

Clinical Depression Screening Test - General Hospital
This quiz helps you determine if you or someone you know is suffering from clinical depression. Individuals are asked to check the descriptions that apply to their current situation and their results are given online. Also provides information on treatment, feedback, current issues, and lists of resources and 800 numbers.
http://sandbox.xerox.com/pair/cw/testing.htm/

Yellow Ribbon Program
This is a proactive, preventive outreach program that distributes yellow ribbon cards and gives presentations and seminars about suicide awareness and prevention. Also included are suicide facts and statistics. Frequently updated.

Join Together Organization
Linking resources about substance prevention, use and abuse and related issues. 441 Stuart St., Sixth Floor, Boston Mass 02116, Tel: 617-437-1500. Fax: 617-437-9394.
www.jointogether.org

Boys & Girls Clubs of America (B&GCA)
Nationwide non-profit youth organization that helps young people get involved with opportunities for personal achievement and growth. B&GCA offers programs that help build good citizens through recreational, social and instructional activities.
www.bgca.org

Parent Teacher Association (PTA)
The National PTA has developed an online resource for parents, teachers and students to address violence issues. National PTA, 330 N. Waash Ave., Suite 2100, Chicago, IL 60611. Tel: 800-307-4TPA (4782)
www.pta.org

PAVNET
Pavnet online is a “virtual library” of information about violence and youth-at-risk. It is a “one-story”, search-able, information resource which provides listing of organizations and programs. Call John Gladstone at 310-504-5462 or e-mail igladstone@nalusda.gov.

Appendix F: Suggested Reading/Bibliography

Children & Adolescents

No One Saw My Pain - Why Teens Kill Themselves by Andrew Slaby, M.D., and Lili Frank Garfinkel

Helping Your Depressed Child - A Reassuring Guide to the Causes & Treatments of Childhood & Adolescent Depression, by Lawrence L. Kerns M.D.

It's Nobody's Fault – New Hope and Help for Difficult Children and their Parents, by Harold S. Kopelewicz, M.D.

The Suicide of My Son - A Story of Childhood Depression, by Trudy Carlson

Children & Adolescents with Mental Illness - A Parents' Guide edited by Evelyn McElroy, Ph.D.

Sad Days, Glad Days, by DeWitt Hamilton (a storybook for children about adult depression)

Helping Your Depressed Teenager - A Guide for Parents and Caregivers, by Gerald D. Oster, Ph.D., and Sarah S. Montgomery, MSW

Perfectionism – What's Bad About Being Too Good? by Miriam Adderholdtt-Elliott, Ph.D.

The Power to Prevent Suicide - A Guide For Teens Helping Teens, by Richard E. Nelson. Ph.D., and Judith C. Galas

Suicide

Suicide Clusters, by Loren Coleman

Suicide: Survivors - A Guide for Those Left Behind by Adina Wrobleski

Suicide – Why? by Adina Wrobleski

Suicide: The Forever Decision - For Those Thinking About Suicide, and For Those who know, Love, or Counsel Them, by Paul G. Quinett

Suicide: Intervention and Therapy – Undoing the Forever Decision, by Paul G. Quinnett.

Child Survivors of Suicide,- A Guidebook For Those That Care For Them, by Rebecca Parkin with Karen Dunne-Maxim

Suicide Survivors – Handbook by Trudy Carlson

After Suicide, by John Hewitt

Choosing to Live - How to Defeat Suicide Through Cognitive Therapy, by Thomas E. Ellis. Psy.D. and Cory F. Newman, Ph.D.

Preventing Youth Suicide – A Handbook For Educators & Human Service Professionals, by Marcia L. McEvoy and Alan W. McEvoy.

An In-Depth Look at Why People Kill Themselves, by David Lester. 1997, Charles River Press

SOS - Runaways and Teen Suicides: Coded Cries for Help, by Sally Brown, Loren Coleman, Robert Schroff, and Carol Buggis

SOS: Coded Cries for Help (video) produced by Dan Porter, Loren Coleman, Ted Miles, and Mara Janelle

Why Suicide?, by Eric Marcus

A Parent's Guide For Suicidal and Depressed Teens, by Kate Williams

No Time To Say Goodbye, by Carla Fine

Adult Children of Suicide - Characteristics and Risk Factors, by Frank Campbell, MSW

The Caregiver as Survivor, by Iris Bolton, the Link Counseling Center, Atlanta, GA

Treatment of Survivors, by Sam Heilig, MSW, Private Practice, Los Angeles. CA

The Suicide of My Son - A Story of Childhood Depression, by Trudy Carlson

Autobiographies

Darkness Visible - A Memoir of Madness, by William Styron

The Beast - A Reckoning with Depression, by Tracy Thompson

Brilliant Madness, by Patty Duke

An Unquiet Mind, by Kay Redfield Jamison

Finding Your Way Through Grief

A Grief Observed, by C.S. Lewis

My Son, My Son, by Iris Bolton

Companion Through the Darkness - Inner Dialogues on Grief by Stephanie Ericsson

Giving Sorrow Words, by Candy Lightner

Life is Goodbye Life is Hello - Grieving Well Through All Kinds of Loss, by Alla Bozartli-Campbell. Ph.D.

The Grieving Child: A Parents Guide, by Helen Fitzgerald,

When Dinosaurs Die - A Guide to Understanding Death (a storybook for children), by Laurie Krasny Brown and Marc Brown

Helping Children Grieve, by Theresa Huntley

Talking About Death - A Dialogue between Parents & Child, by Earl A.Grollman

Remembering with Love, by Liz LeVang, and Sherokee Isle

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Gay Suicide

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Case History #1

Kalae is a 15 year old male, who has been behaving differently over the past month. He is usually a friendly, outgoing boy who enjoys being with friends, and tries to keep up with school work. Recently he hasn't been participating in class, hasn't completed assignments, seems distracted / dull, lacking energy or motivation, not even seeming to smile or enjoy being with friends.

Student:

You have become increasingly depressed over the past month, feeling sad all the time, having trouble falling asleep and waking up frequently during the night so that you only end up with about 4 hours of sleep. You wake up tired and feel tired and run down during the day. You don't feel hungry anymore and have been losing weight. Life has been feeling hopeless. You feel you must be a failure because you can't get the grades you used to get and you blame yourself, feeling something is wrong with you because friends don't want to be with you anymore, so you isolate yourself from everyone. It's hard to laugh and when you do it feels like you're faking it. You don't use drugs and although you've drank before, you don't do it on a regular basis. Your family is supportive.

You have started thinking that it would be better to be dead. That way your parents wouldn't have to worry about you anymore and you wouldn't be a problem to anyone.

You have thought about suicide and have considered getting a rope and hanging yourself when the rest of the family goes out this weekend. You have been thinking seriously about hanging yourself, but you don't know if you can really do it. You just want to stop feeling so bad.

Case History #2

Leilani is a 16 year old female who frequently comes to class “moody” - sometimes sad, sometimes angry, sometimes a combination of both. You have talked to her before and know that she has a history of family problems - chronic conflict with her mother. Her parents have been divorced since she was 2 and she has no contact with her father. She is a bright girl, and capable of making good grades, but has been so distracted by her problems that she doesn’t complete any assignments and is in danger of failing her junior year. Just before class, you see her arguing with her boyfriend in the hallway and she is crying with her head down on her desk in your class.

Student:

You are feeling unloved and unsupported by your family. Your mother doesn’t want you to spend so much time with your boyfriend and is constantly nagging you to get off the phone with him and do your homework. Your mother always criticizes you and is disappointed in you. You feel that your boyfriend is the only person who cares about you, and now he wants to break up with you. You can’t imagine how you will survive without your boyfriend.

- Life is feeling hopeless.
- You’re not sleeping well.
- Low energy level
- Concentration is poor
- You’ve never attempted suicide before
- No one in your family has attempted or completed suicide that you know of
- One of your friends has made a suicide attempt recently
- You have been thinking about what it would be like to die - not to have to struggle so much anymore.
- No suicide plans, no intentions to hurt yourself
- No warning signs
- You are able to form a *suicide contract* to not harm yourself and tell this teacher if you do feel suicidal
- You agree to see the counselor and to talk to the teacher

Case History #3

Pono is a 15 year old male whom you have known for 2 years. He is very popular among his peers and has always been very friendly and willing to joke with teachers. He has been a good student, attends class every day and is usually eager to participate in class activities. Since coming back from summer vacation, you notice that his grades have dropped. He still attends class, but seems more distracted. You notice that he no longer hangs out with his group of friends, but spends more time along. In class he writes a poem called “The Black Hole” describing how desperately he wants to escape from what seems like a hopeless situation.

Student:

You’ve started using crack cocaine over the summer vacation and are hooked on it. You go on binges - feeling euphoric for a while - then crash, becoming severely depressed and suicidal. You don’t know how to escape from this roller coaster. Without the crack you feel depressed, but you know that the depression only gets worse when you use crack and then you crash. You used to feel close to your family, but they don’t understand you anymore.

- You’re not sleeping well on nights when you’ve been binging on crack. But other nights when you’re depressed, especially after a binge, you sleep all night and all day.
- Your appetite is poor and you’ve lost weight. Even your family has commented on how thin you look.
- You used to feel OK between crack binges, but now you feel depressed all the time.
- Life feels hopeless.
- Nothing is fun anymore.
- Your concentration is poor.
- You have been thinking almost constantly about suicide for the past month, because life is just too hard to handle.
- You have thought about using your father’s hunting rifle to shoot yourself. Although you haven’t decided on whether you’re bold enough to go through with suicide, you have already hoarded your father’s gun and bullets in your bedroom.

Case History #4

Brandy is a 14 year old female who frequently cuts class, so you don't know her very well. When she does come to class, she is often irritable and sassy, talking back, and easily angered. She has gotten into several fights with peers and has difficulty controlling her anger, tending to act impulsively. Malia hangs around with a gang of girls who frequently get into fights and whom you suspect are using drugs. On this day she comes to class sullen with red slashes on her left wrist.

Student:

You have been fighting with your mother over your boyfriend. Your mother doesn't like you seeing him and you have been sneaking out of the house to be with him. Your period has been late and you are worried that you are pregnant. You are certain that your mother will never forgive you for getting pregnant and are worried that your boyfriend will not understand when you tell him that you want to keep the baby.

This morning before school you got into another fight with your mother and in frustration and anger grabbed a butter knife and made several slashes on your wrist. You wanted to die at the time and still think about it, but now that you've calmed down and feel in control, you aren't sure what to do.

This is not the first time that you have gotten pregnant. You had an abortion before and don't want to go through with it again.

You feel depressed almost all the time and have felt really depressed for over a year but you have never felt really happy in your life.

Your family is always a mess. Your father is in jail for attempted murder and he shot himself in the face when he was 16, in a suicide attempt. Your mother divorced him when you were 2 years old. You had a stepfather whom you really liked, but he died suddenly when you were 8 years old, and you still feel the loss. You have never really gotten along with your mother and you feel that she doesn't really love you. She always favors your younger step brother and step sister.

- You don't sleep well, taking 1-2 hours to fall asleep
- You usually don't feel energetic, but when you're angry to feel too energetic and agitated, unable to calm down
- You don't feel things are hopeless yet, but don't know how you'll ever straighten things out.

- You have made previous attempts by overdosing on tylenol and cutting your wrists.
- You think of suicide frequently when stressed out and are thinking about it now.
- You have no well thought out plan. You aren't really seriously contemplating it. You have calmed down enough that if someone offered you a sure fire way to die, you don't think you would take it.
- You are able to form a *suicide contract* and want to talk to someone.

Case History #4

Ashley is a 17 year old female who is an average student and comes to class, but often seems distracted. She tries hard but has difficulty making good grades. She is someone that doesn't confide much in teachers or peers and tends to hold her feelings in. Semester grades came out last week and she received two D's. She has been absent from school for a week and today returns to school appearing sad, tending to isolate herself from everyone.

Student:

You and your family expect too much academically. You try hard, but make mostly C's with a few B's. But on this last report card you received F's in math and social studies and you feel you can't face your family. You feel you have let yourself down. Your family is counting on you to go to college - since no one in the family has even graduated from high school with a diploma. You have been feeling depressed for the past month, knowing that you weren't doing as well in several classes.

- Sleep has been poor
- Appetite OK
- Energy level OK
- Still able to enjoy things but just too worried to enjoy life

A week ago when you learned of your semester grades, you took an overdose of pills - a little bit of everything you found in your parent's medicine cabinet - about 30 pills altogether - a combination of tylenol, your father's pain killers, your mother's blood pressure medicine and some other pills. You really wanted to die, feeling there was no way you could face your family or yourself. You felt like such a failure and you still do.

You locked yourself if your bedroom and turned up the stereo so no one would figure out what had happened and prepared to fall asleep and die. Your mother broke into your room and found you unconscious - called the ambulance and you were kept in the hospital for several days. You are now returning to school and have yet to accept that you failed two classes. You don't want to face your teachers. You don't want to face your peers.

- You are still feeling very depressed.
- You are not sleeping well - stay up all night worrying about things
- You regret putting your family through the stress of finding you after the suicide attempt, and feel bad that there are so many hospital bills they will have to pay.
- You are still feeling that life is hopeless and don't know how you will graduate from high school, much less go to college now that you've failed these courses.
- You don't see how you can continue to live life when you won't graduate from high school or go to college.
- You are still thinking that suicide is an option if things don't work out and have been thinking about how you will do it better this time - to be sure that no one finds you.

- You haven't formed any concrete plans, but have been thinking about jumping from a tall building. You don't know which building that would be.
- You feel that you can form a *suicide contract* not to hurt yourself for now, but don't know if you can keep that promise, if things get worse.

Case History #5

Justin is a 17 year old male, who has had a number of disciplinary problems. He is frequently truant from class and is usually a behavioral problem when he does come to class. He has been suspended three times this year for insubordination and fights and you think that he may have been arrested as well. Although he is not highly verbal, you have a rapport with him. You see him arguing with his girlfriend, just before class. When he comes to class he is angry, agitated and he is stabbing himself in the leg with his pen to the point that it is drawing blood.

Student:

You feel angry and depressed a lot of the time. You have a few friends who are already out of high school and don't really have any friends in school. You are easily irritated and will fight with anyone who gets in your face. You aren't happy with your life, but have a 14 year old girlfriend, who makes coming to school more worthwhile. Recently you have been getting into fights with your girlfriend and you suspect she might be seeing someone else.

You use ice and marijuana regularly. People say the ice makes you paranoid and irritable, but you don't believe them.

You think about suicide, but have no plan or intention of killing yourself.

But you do things to hurt yourself when you are angry and you don't have any control over this behavior. You often punch the wall and have broken your hand twice. You have burned yourself with cigarettes and cut yourself with kitchen knives, to release the anger.

Your family doesn't support you. Your father drinks and uses drugs. Your mother tries to control you, but you don't listen to her. You have an uncle that you are close to, but he moved to Vegas last year.

You aren't sleeping well because of the drugs. Your appetite is poor. Your energy goes up and down, depending on when you use the ice.

Right now you have thoughts of suicide, but don't plan to do it. You do not feel in control of your behavior, but mostly feel like stabbing yourself with the pen and feel that will make it better.

You plan to see your girlfriend again after school and plan to confront her about going out with other boys.

Beach Ball Boogie

This is a great large group energizer activity which can teach simple team building concepts.

OBJECTIVES:

1. To allow students to participate in a cooperative learning activity
2. To learn to work together

GROUP SIZE:

Unlimited, however if you have 100 or more students, you may want to split them up into two equal groups.

TIME FRAME:

15 –30 minutes

MATERIALS:

Beach Balls of various sizes, about one for every 20 students

PROCESS:

Have the students sit in a tightly packed square or rectangle. They may be sitting on chairs or on the floor, but everyone must remain seated throughout the entire activity. The object of the activity is to keep a ball up in the air for as long as possible. The trial ends if the ball hits the ground or if it goes outside of the section defined by the outside row of seated players.

Throw a single ball into the section and put a clock on their effort. Remember for safety reasons everyone must remain seated at all times. Add another ball and see how they do. Keep adding balls to make it more difficult. Once you have introduced all of the balls, give the group some time to brainstorm on techniques. Time each trial and go for the worlds record.

A second version of this game can include splitting your sections into two even numbers. The two groups can then compete against each other to keep the balls up and in their sections the longest.

DEBRIEF:

How was the activity? What did you learn? What techniques worked the best? What were the challenges? What did it take to be successful? Can you relate what you have learned to the real world?

Balloon Up

This is a great team building activity, that will challenge everyone no matter what the age.

OBJECTIVES:

1. To teach students to work together in a common effort.
2. To allow students to problem solve within a small group

GROUP SIZE:

4 to 8 students in a group

TIME FRAME:

20-30 minutes

MATERIALS:

1 Medium sized balloon for each pair of students. Large flat, clear area, enough for people to move quickly without getting hurt.

PROCESS:

Instruct students to form pairs. Have a representative from each group come up to you to get a balloon. Blow up the balloon to ¾ maximum, and tie it off. The task is to keep the balloon up in the air as long as they can. They can use their heads feet, arms hands or whatever they want to bat the balloon up into the air. The only restriction is that the group must be holding hands at all times. Talk to your group about safety, they will have to be aware of each others positions and movement (kicking above the waste should be disallowed).

When the group is ready have them toss the balloon in the air and practice. Introduce the next challenge; ask the pair to join another pair to form 4 people with two balloons between them. Combine two fours to make eights with four balloons and so on. When you have gotten to one or two large groups, give the groups time to brainstorm. This time challenge the groups and use a clock to time their effort. As soon as a balloon touches the ground or the linked hands chain is broken, stop the trial. Work towards the days "world record."

DEBRIEF:

How was the activity? What did you learn? What techniques worked the best? What were the challenges? What did it take to be successful? Can you relate what you have learned to the real world?

Go Get Um, Go for It!!!

YOUR NAME _____

DIRECTIONS: Do everyting listed below and get da signatures fo prove um!

1. Get someone fo do 5 sit-ups for you. Hold deya legs and count!
   Sit-up person sign hea:_____

2. Get tree udda people and you, fo bok bok like one chicken to the song, jingle bells.
   Sign hea_____&hea_____& hea_____.

3. Find someone dat tinks opihi tastes ono.
   Sign hea:_____

4. Find someone wearing someting from one surf shop.
   Sign hea: _____

5. Find someone dat wen bring slippas.
   Sign hea:_____

6. Find somebody dat neva go paradise park.
   Sign hea: _____

7. Get someone fo tell you one clean joke.
   Sign hea: _____

8. Find two people dat can name one pokeman characta.
   Sign hea: _____ & Hea _____

9. Get five udda people and you fo group hug!
   Sign hea:_____hea_____hea:_____
   hea:_____ & hea_____

10. Ask someone what dey hope fo get out of dis training.
    Sign hea:_____

Validation And Praise

This is a powerful self esteem oriented activity. It can be done as an initiative activity, but it is usually more meaningful after the class gets to know each other better.

OBJECTIVES:

1. To find out how others see you.
2. To reinforce your own image of yourself.
3. To learn to give and receive positive feedback.

GROUP SIZE:

Unlimited

TIME FRAME:

Approximately 30 min. for a group of 20

MATERIALS:

14 inch X 14 inch Oak Tag or half sheets of chart paper. Colored markers for each student.

PROCESS:

Give students a large construction paper, or a half .sheet of chart paper. Ask each student to draw a big circle in the middle of their paper. Instruct students to write words that best describe them inside of the circle. Write as many positive words as possible, and encourage students not to be modest. After 10 minutes or so, tape the papers to the students backs. Instruct students to go around the room and write positive words on the outside of each person's circle. They are not limited to just one word, the better they know the person the more words they will be apt to use. Meeting students for the first time allows them to give first impressions of each other. You may want to do this activity several times to see how the impressions of each other change.

DEBRIEF:

How was it writing words for yourself? Did you feel conceited? Did you think other people would think you were conceited? Was it easy to write on other students papers? When you looked at what other people wrote on your paper, were you surprised? Did the words match what you think of yourself? How did it feel to get positive feedback? How did it feel to give positive feedback?

Appendix I: Ohana Group Activities

Overview

The topic of suicide is often very difficult to cover due to the strong emotional responses it creates. The Native Hawaiian Gatekeepers training will utilize "Ohana or family groups" to help process the experiences of the training. The Groups will include representation from each school and each of the different occupations which make up your team.

Directions For Ohana Group meeting #1 (Mon. Sept. 13th 9:30am)

1. Your name tags include a sticker which represents your assigned Ohana Group. Your first task is to find all of the other people with the identical sticker and sit with them in a circle.
2. One of the conference facilitators will be assigned to your group to help you navigate through this first part of the journey. Ohana sharing guidelines:
    a. Confidentiality: What is said in your Ohana group stays in your group. Sharing with the larger group is always optional.
    b. Mutual Respected: We will ask everyone to celebrate our differences and learn to accept that there are many different beliefs and points of view.
    c. The Right to Pass: We would like to encourage everyone to share, however, you will always have the right to pass or defer to another time and place.
    d. Everyone Participates: We ask that everyone be present for all sharing, even if you are only listening, you are participating.
    e. Put ups only!: No put downs to self or others please.
3. Go around the circle and introduce yourself to your new adopted family.
    a. Please start with your full name and what it means, or how you got it?
    b. Where do you come from?
    c. What is your current occupation?
    d. How many years have you been doing this?
4. Go around the circle once again and share with the group:
    a. Brothers and Sisters
    b. Your parents full names and nationalities, where they came from?
    c. Grand Parents, nationalities and where they came from
    d. Great grand parents, and where they came from
3. Open Discussion: Discuss the importance of family and culture as it relates to dealing with stress, and coping with life crisis.
4. What are the beliefs in your family surrounding suicide?
    Do they differ from the culture?
    If so, then why?
5. Share a personal experience with regards to the topic of suicide?

6. Facilitator's chart: How do you think we can help prevent suicide?
7. List your concerns
8. Share the lists with the larger group. * Remember the "confidentiality" guideline, and ask your group if there is anything they would like to keep confidential.

OHANA GROUP #2 (Mon. Sept. 13th 7:00pm)

1. Open Discussion: Discuss the day's activities and sessions.
    a. Chart any BURNING questions or concerns???
    b. List areas that are still unclear?
2. Reflections: Chart feelings and emotions that were experienced
3. Suggestions/Feedback: Anything about the training so far that you would like to comment on, good, bad, needs improvement.

OHANA GROUP #3 (Tues., Sept. 14th, 8:00am)

Share charted reflections

OHANA GROUP #4 (Tues. Sept. 14th 3:00pm)

1. Open Discussion: Feedback on the Native Hawaiian Gatekeepers training
    a. How did the training go for you?
    b. Feedback/ Insights
    c. Comments and suggestions
    d. Words of hope and wisdom
    e. Mahalo, farewells, well wishes
2. Fill Out Feedback Forms
3. Validation and Praise Activity
    a. Everyone gets a pen
    b. Everyone gets a piece of paper taped to your back
    c. Write positive words that describe your impressions of the person
    d. Walk around the room and write on as many people as you can
    e. Debrief

Cultural Sharing Activities

Native Hawaiian Gatekeeper Training Agenda

Day 1

Monday, September 13, 1999

7:45-8:00AM REGISTRATION (Eric)

8:00AM OPENING
BLESSING (Kupuna Elizabeth Kauahipaula))
INTRODUCTIONS/RECOGNITION OF GUESTS (Dan)
PROJECT OVERVIEW OF THE ALASKA/HAWAII COLLABORATION (Eric)
TRAINING OBJECTIVES (Noelle)

8:30AM EXPERIENTAL LEARNING ACTIVITY (Dan)
"BALLOON UP"/ "GO GET 'UM" - Distribution of workshop packets

8:45AM THE PROBLEM OF SUICIDE (NATIONAL AND HAWAII DATA) AND THE ROLE OF THE GATEKEEPER (Noelle)

9:00AM STORIES FROM SURVIVORS
(Mrs. Oyama, Alaska visitors)

9:30AM OHANA GROUPS (Dan)
INITIATIVES
PROCESS SUICIDE EXPERIENCES

10:15AM BREAK

10:30AM MYTHS AND FACTS ABOUT SUICIDE (Noelle)

11:00AM CULTURAL SHARING (Kauanoe & Kanani Taliaferro)

11:30AM LUNCH

12:30AM EXPERIENTAL LEARNING ACTIVITY (Dan)
"BEACH BALL BOOGIE"

1:00PM RISK AND PROTECTIVE FACTORS FOR SUICIDE (Noelle)

2:00PM WARNING SIGNS AND CLUES (Noelle)

2:30PM CULTURAL SHARING (Keone Nunes)

3:00PM HOW TO TALK TO KIDS ABOUT SUICIDE (Noelle and Analika)
- ASSESSMENT AND TRIAGE
- CASE SCENARIOS AND ROLE PLAY

4:30PM BREAK

6:00PM DINNER

7:00PM OHANA GROUP (Dan)
- PROCESS
- QUESTIONS AND CONCERNS
- REFLECTIONS

8:00PM CULTURAL SHARING (Analika)
- MUSIC AND DANCE (Sharing from Schools)
- STORIES AND FELLOWSHIP - Sharing from Alaska

10:00PM PAU HANA !

DAY 2

Tuesday, September 14, 1999

7:00AM BREAKFAST

8:00AM OHANA GROUPS - SHARING, REFLECTIONS (Dan)

8:15AM BLESSING / CULTURAL SHARING (Analika)

8:30AM REFERRAL PROCEDURES (Noelle and Analika)
(SCHOOL TEAMS)

REVIEW AND REVISE CRISIS RESPONSE PLANS
REFERRAL PROCESS
FLOW CHART AND DEBRIEF

10:00AM BREAK

10:15AM GATEKEEPER TRAINING PLANNING (Everyone)
WHO? WHAT? WHEN? WHERE? HOW?

12:00PM LUNCH

1:00PM GATEKEEPER TRAINING PLANNING CONTINUED (Dan)
2:00PM PRESENTATIONS OF GATEKEEPER TRAINING PLANS BY SCHOOL TEAMS

3:00PM OHANA GROUPS (Dan)
REFLECTIONS
SUMMARIZE
"VALIDATION AND PRAISE"

4:00PM CLOSING
MAHALOS (All)

BLESSING